North Carolina Pharmacist

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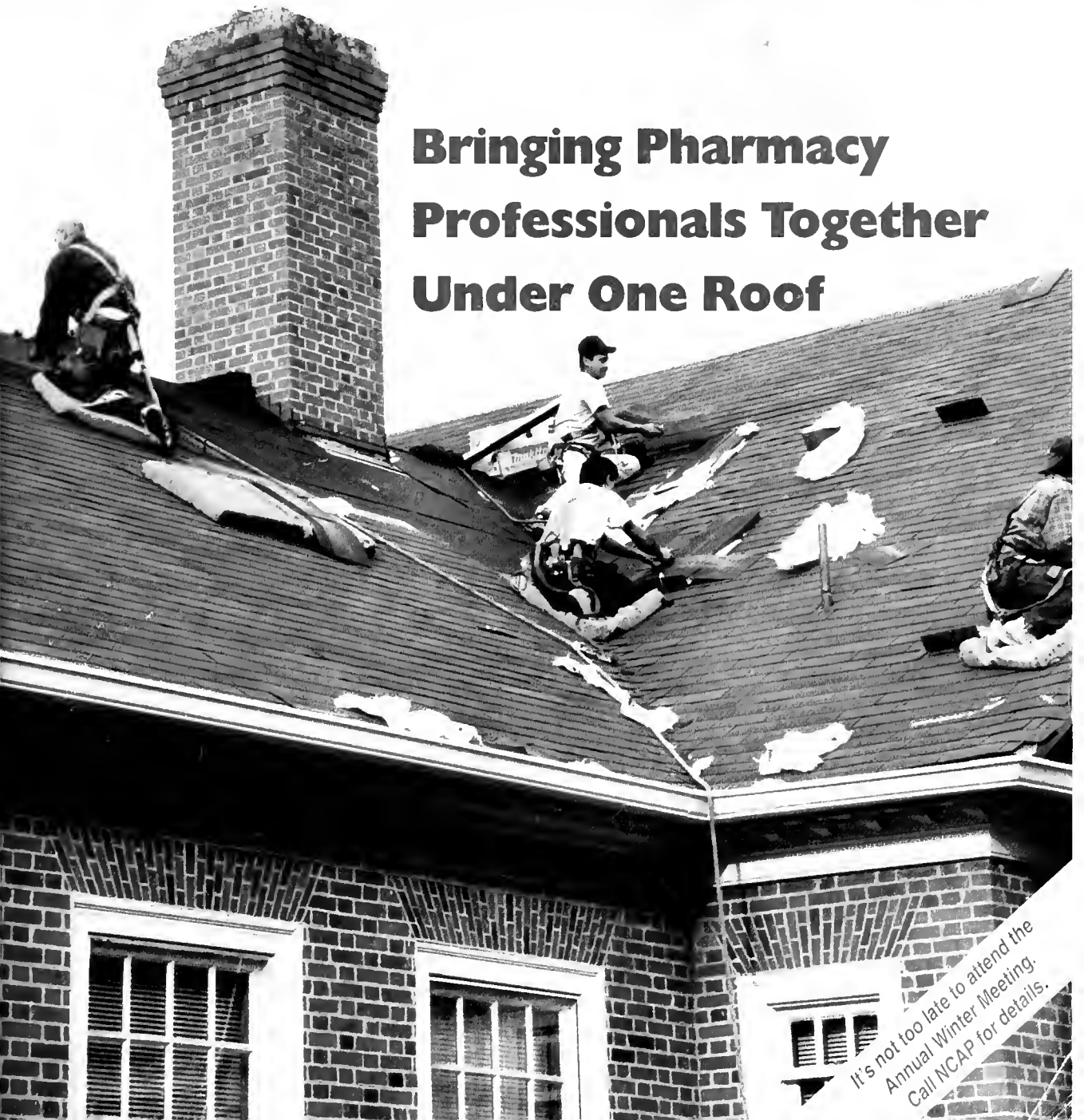
Bringing Pharmacy Professionals Together Under One Roof



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North Carolina Pharmacist

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About the Cover

Renovations, including a new roof, are underway at the Institute of Pharmacy. Read more about this in Voice & Vision on page 4, and find out how the Auxiliary is assisting with this effort on page 24.

Cover photo by George A. Rideout

Inside

Daniel G. Garrett
Executive Director

NCAP, the "New Roof" for Pharmacists in North Carolina

The Institute of Pharmacy has a new roof. Our building was built in 1949 and was the first building in the country owned by a state pharmacy organization. Over the years our roof has had to weather many storms and was badly in need of replacement. The old roof was torn off and a new one has been put in its place.

This new roof is a significant symbol of the new umbrella that NCAP is providing for pharmacists as we begin a new millenium. It is an interesting coincidence that the week we replaced our roof we marked the passing and celebration of the life of W. J. Smith. W. J. served as the Executive Director of the North Carolina Pharmaceutical Association from 1940 to 1978. Towards the end of the Great Depression, W. J. and his wife Vivian began to working tirelessly to build our association into the most respected state association in the country. W. J. was the coalescing force that enabled pharmacists in North Carolina to build the Institute of Pharmacy and put the first roof over pharmacists in our state.

Additional renovations have been made to the Institute's electrical and ventilation systems. Once again, the Auxiliary has contributed to our office by providing a new color printer and fax machine, and refurbishing the rose garden. These improvements to our facility are a daily reminder of the commitment NCAP members and supporters are making to our unified vision for pharmacy.

NCAP had many accomplishments in the year 2000:

- Worked with the Board of Pharmacy and the Medical Board to develop the Clinical Pharmacist Practitioner Regulations
- The transition of the Asheville Project into the Diabetes Community Health Project
- Working in the legislature to protect pharmacy reimbursement
- Hosted the Workplace Issues conference
- Created the NCAP website
- Successfully implemented the first year of our Three-Year Strategic Plan

These are just a few of the many areas in which we have had success. We are now well on the way to achieving more in 2001 including:

- Working with the State Health Plan to develop a pilot program for pharmacist asthma management for pediatric patients
- Setting an aggressive legislative agenda for the long session
- Planning a Pharmacy Residency Leadership Program
- Providing a speakers bureau for local associations
- Planning three state-wide CE meetings

The Annual Implementation Plan calls for 38 action items and our councils, practice forums, board and staff have hit the ground running.

Two major events will give NCAP the opportunity to show North Carolina our new "roof."

The first big event will be the Pharmacy Leaders Forum. NCAP has taken responsibility for planning a meeting that will include Pharmacy Benefit Managers, Health Plans, State Government, National Pharmacy Leaders, Board of Pharmacy and NCAP leaders. This historic meeting is a follow-up to last year's Workplace Issues Conference and marks the first time anywhere that all of these groups will be under one roof. We will be addressing third-party claims processing issues, expansion of pharmacist reimbursement for clinical services, and patient medication safety. This meeting is drawing national attention and our goal is to identify short-term actions that we can take to improve pharmacy workplace conditions, get paid for pharmacist health management, and reduce medication errors.

The second big event will be our initial NCAP House of Delegates. The HOD will meet for the first time on October 29, 2001 at our Convention in Greensboro. Each local association, practice forum and school of pharmacy will have representation as we consider resolutions on policy and direction for North Carolina pharmacy. This will be a landmark event that sets the tone for our vision for the future as a profession united under one roof.

You can help us get the most benefit from our new roof by recruiting more North Carolina Pharmacists to join NCAP. We have a lot of room under our new roof and the more pharmacists we have sharing our vision, the louder our voices will be heard.

I imagine that W. J. Smith is smiling when he looks down and sees our new roof. Please pass along the word to other pharmacists that NCAP is keeping alive the legacy of service to North Carolina pharmacy, and to our patients, that W.J. and Vivian helped build. ❖

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William L Harris, Jr.
President, NCAP

Dear NCAP member,

The new year brings an opportunity to remember past accomplishments, but more importantly, it allows us to focus on what we can do to advance the profession this year and in the future. The NCAP Three-year Strategic Plan provides direction for developing our Annual Implementation Plan (AIP). The 2001 AIP includes twelve goals and thirty-eight planned actions to achieve these goals. These goals include meeting the educational and professional needs of our members, strengthening our organization and our relationships with other healthcare professions, passing key legislation, monitoring all legislation, improving the role and utilization of pharmacy technicians, improving and expanding professional opportunities and becoming more unified as a profession. However, the NCAP Board selected "communicating the value of pharmacy to the public" as top priority for 2001.

Let's not consider this a task but rather a return to the basics of pharmacy practice. Our profession endears the memory of the pharmacist in the corner drugstore in a community that lovingly called him or her by first name, or just "Doc." Patients enjoyed a professional, yet personal relationship with pharmacists, felt comfortable discussing health problems with pharmacists and readily sought medical and treatment advice. We need to renew that personal relationship with our patients. It is key to their understanding the professional services, both technical and cognitive, that occur during review, processing, preparation, monitoring and performing other professional actions that evaluate, individualize, and enhance their medication therapy and ensure safe, effective medication use.

High tech solutions to high volume problems and personnel shortages altered our practice in all practice settings. Pharmacists moved farther from the patient to telephones, computers, compounding labs, I.V. rooms, consultant offices, drug information centers, central fill locations and mail order facilities. How can patients know what you do for them behind the scenes if they only see the final "product"? We need to remove the barriers and find new ways to communicate the value of the pharmaceutical care activities that occur but are unseen and unknown. Remember that patients do not pay you for what you know, but will pay you for what you do for them.

This is not just a goal for community practice. Pharmacists in hospitals, clinics, nursing homes, hospice care, consulting roles, pain management, nutrition, kinetic dosing, drug therapy management, collaborative clinical practice and other settings must implement ways to communicate their contributions to successful patient care. Both patients and those who pay for healthcare services must become educated about your value. Who better to communicate this than the one who provides the care? Old "Doc" built that reputation one patient intervention at a time because it was personal.

There are indications that pharmacists are close to achieving provider status and reimbursement for defined patient care services. But we need more recognition by the public, payers and those who affect regulations. We must move beyond pilot programs and demonstration projects. The Asheville Project was a success. Patient care improved, patients are more satisfied and pharmacists are being paid because they make a difference. The patients convinced their employer (and healthcare payer) that pharmacists changed their lives. That is a powerful message.

We must make this happen in every community in North Carolina, in every setting where a pharmacist can form a professional relationship with a patient to provide the pharmaceutical care that will make a difference that the patient and the payer recognize. A motivational phrase often quoted from the movie "Jerry Maguire" is "Show me the money." However, a better message from that movie is "It's all about relationships." We must build patient relationships to be successful.

NCAP can facilitate this process by providing information, contacts and mentors and by sharing success stories. Tell us what works for you and how patients perceive it. Let NCAP publicize your success story via the journal, web site or CE program. Work with newspaper, radio or television reporters to produce a feature about the services and care that you provide that creates a win-win situation for the patient and you. Write a letter to the editor of your community newspaper. Pharmacists must achieve this goal or risk losing funding for operations and losing professional opportunities.

Relationships are built one patient at a time. Begin today by personally letting your patients and community know about the difference you make for them as a pharmacist.

Communicating the value of pharmacy....one patient at a time.

Sincerely,
William L. Harris, Jr., President

...applying drug knowledge to improve health

Above and Beyond the Mechanics of Dispensing

by Kim Griswold

The evolution of the pharmaceutical care model inspired pharmacists to provide services above and beyond the mechanics of dispensing. The Clinical Pharmacist Practitioner Act (CPP) will allow an additional avenue for pharmacists to be the medication managers they were trained to be. It provides an exciting opportunity for interested physicians to direct a healthcare team whose goal is to optimize drug therapy in the community. Physicians will experience a reduction in their number of interruptions by having pharmacists, as the drug specialists, apply their skills and address drug specific issues directly with the patient. A well-defined agreement outlining the pharmacist's prescribing privileges will be established between the prescribing physician and the pharmacist.

Biologics, Inc. of Raleigh, NC was established in 1994 as a pioneering retail practice setting serving the ambulatory oncology patient population. Independently owned, freestanding and licensed as a retail pharmacy, Biologics offers distinguishing patient services such as private counseling, detailed written and audio-visual teaching materials, symptom management and support in the home while the patient is receiving medications from Biologics. The primary therapies managed by Biologics include the biological response modifiers, oral chemotherapeutic agents, anti-emetics and supportive oral medications for cancer patients. Patient management varies in its intensity from previously untreated naïve patients to bone marrow transplant recipients. Our practice model evolved around the concept of pharmaceutical care. Under the umbrella of the CPP, our qualified pharmacists will become even more significant participants in the drug therapy management of cancer patients.

Oncology is a very tightly knit community of healthcare providers managing a complicated disease. Cancer patients have multiple needs. Frequent contacts with oncology specialists are necessary. This allows reciprocal relationships to develop between our pharmacists, physicians and their clinicians. Biologics' pharmacists monitor patients in the home. Information gathered is documented and relayed to the patient's healthcare team allowing collaborative decisions to be made with the patient. This type of interaction provides a framework for managing and optimizing drug therapy outcomes and expands our relationships with healthcare providers. The fundamentals of the relationship promoted by the CPP Act already exists for us. We must develop a personal plan for each pharmacist interested to fulfill the credentials mandated for the CPP role if they do not already qualify. Whether it is through certificate programs, residencies, or board specialty designation of any nature, the cancer patient will ultimately benefit from the pharmacist's practice specialty. Not only is a cancer patient's disease and medication regimen difficult to manage, but their underlying disease management issues, prior to their cancer diagnosis, cannot be ignored or forgotten. Comprehensive management is enhanced when pharmacists are skilled in areas other than oncology.

Biologics' patients require routine symptom management. Follow-up in the home begins on the day of dispensing and subsequent contact is based on the potential for adverse events, side effect profiles or patient request. Our pharmacists also assist in managing symptoms related to recent chemotherapy treatments received in the clinic, office or hospital setting, in addition to counseling patients on medications dispensed by Biologics. Often times, patients are reluctant to contact their physician outside of office hours for symptom relief. Our pharmacists are available 24/7 with easy access. Complaints range from minor to intermediate in intensity. When problems or events are documented, the physician or clinician prescribing is contacted immediately to offer a recommendation. Symptom management can be standardized to a degree using medications designated in a collaborative agreement. We initially anticipate establishing a collaborative practice agreement with some of our referring physicians within a few classes of drugs. For example, prescriptive authority to alleviate nausea and vomiting related to chemotherapy could prevent or minimize potential complications from dehydration, electrolyte imbalances and malnutrition. Anticipated side effects associated with the addition of growth factors (Neupogen, Procrit, etc) or alfa interferon to a patient's regimen provides another opportunity to develop a standardized treatment plan from which pharmacists can have limited prescriptive authority in order to minimize patient discomfort.

Developing a collaborative care plan for symptom management would allow a pharmacist to make alterations to a

patient's drug regimen without delay and could minimize or eliminate symptoms for the patient without interruption to a physician's schedule. The implementation of the CPP Act will expand the role of our pharmacists to allow in the sharing of patient outcomes; to make decisions regarding drug prescribing, to make adjustments to patients' regimens and to monitor until the desired outcome is achieved.

Reimbursement issues plague even the most unique pharmacy practice settings. Spending a great deal of time managing a patient erodes slim profit margins even further. We continue to service the patient and our physician referral sources in such a manner to provide benefit to the patient as we are trained and licensed to do. We bill for cognitive services routinely, but are paid sporadically. Ultimately, we hope to achieve reimbursement worthy of the services we deliver. The CPP Act may provide the necessary credentials to gain payment recognition for our services from insurance providers and PBMs.

As pharmacists, we must become integral members of the healthcare team. Our education and expertise can improve drug therapy outcomes, reduce medication errors and assist with disease state management, ultimately improving healthcare for the patient. Every pharmacist is a healthcare consumer and should be driven by that alone to make positive changes in our practice environments. Every idea and opportunity must be explored for its potential to enhance patient/physician/pharmacist relationships in order to ultimately care for the healthcare consumer. Thanks to NCAP, we have one such opportunity. ❖

About the Author...

Kim Griswold, RPh is Director of Pharmacy Services at Biologics, Inc. in Raleigh, NC. She can be reached via e-mail at KGriswold@biologicstoday.com

Fall 2001 Applications for UNC-CH External Doctor of Pharmacy Program

A Special Note: The External Doctor of Pharmacy Program was designed to meet the needs of practicing pharmacists, and to continue operating as long as sufficient interest remained to sustain the Program. Our original estimate was for a 10-year period of operation: 1996 – 2006. In reviewing our recent application and enrollment trends, it appears this estimate may be correct. If so, we may admit only two more classes, one this year (2001) and one next year (2002). Pharmacists who are interested in the UNC External Doctor of Pharmacy Program should be aware that only two additional classes may be enrolled.

In order to accommodate your needs, we need to know if you are interested in enrolling in the Program during the next two years. This information will help us balance enrollment during the remaining life of the Program, plan for an efficient phase-out, and effectively manage our resources. In order to do this, we need your help:

If you intend to apply this year, please contact us to request an application. Applications for the Fall 2001 Semester will be available in January. The application period is from February 1 to May 1.

If you intend to apply next year, please contact the Program Office immediately. We will place your name and address in our records and work with you to be sure your needs are met.

Please know our goal is to serve the needs of the largest possible number of pharmacists by providing access to this outstanding Program. But we need your help to accomplish this goal. Thank you.

Pamela Joyner, EdD, MS
Associate Dean for Professional Education
UNC-CH School of Pharmacy, External PharmD Program
Beard Hall – CB #7360, Chapel Hill, NC 27599-7360.
Phone: 800/257-3561 or 919/962-5000. Fax: 919/843-9255.
E-mail: cathy_hardee@unc.edu

In Memoriam: William Julius Smith

William Julius Smith of Stone Mountain, GA, died Sunday, January 14, 2001 at the age of 89. Mr. Smith served as Executive Director of the North Carolina Pharmaceutical Association for 38 years.

He was born in Morgantown, NC on November 17, 1911 and graduated from the University of North Carolina School of Pharmacy in 1937. He worked briefly in a drug store and then as an inspector with the North Carolina Board of Pharmacy. Later in 1940 he accepted the position of Director of the North Carolina Pharmaceutical Association. He came to NCPhA with vision and hope, dedicated to the interests of the public through pharmaceutical service. When he retired from the Association in 1978 it was one of the strongest and most notable of all such professional groups in the United States. Mr. Smith helped organize and incorporate the North Carolina Pharmaceutical Research Foundation and was a registered pharmacist for 50 years. In 1960 he was honored by the Raleigh *News and Observer* as "Tar Heel of the Week" and cited as the "standard bearer for Tar Heel pharmacists."

Survivors include his wife, Vivian S. Smith, his son and daughter in-law W. Allen and Klara Smith, and granddaughters Vicky Smith and Wendy Smith Player.

Those desiring may make contributions to the Pharmacy Foundation–Smith Scholarship Fund, c/o UNC School of Pharmacy, Beard Hall, CB-7360, Chapel Hill, NC 27599.

William Julius Smith, 1911-2001

Practice Profile

Presbyterian Wesley Care Center

by Kaye Vass

Presbyterian Wesley Care Center is a 289 bed long-term care facility in Charlotte, NC. Built in 1963 by The Methodist Home and leased by Presbyterian Hospital in 1996, Wesley offers a variety of services which include stroke and orthopedic rehab, wound care, pain management, palliative and hospice care. Wesley also provides long-term medical care and has a 50-bed JCAHO accredited Alzheimer's unit. When it was built, Wesley was one of the first long-term care facilities to have an in-house pharmacy. Liz Rittase, our director, was hired in 1973 as the pharmacy's first full-time employee. In addition to the director and a clinical pharmacist, our staff includes two part-time pharmacists, Cindy Hundley and Pearlie Gillespie, and a technician, Beverly Banks.

Being a clinical pharmacist in a long-term care facility combines the best of being a hospital pharmacist and a consultant pharmacist. Like a hospital pharmacist, I am able to round on each unit daily, review new residents' charts on admission, clarify orders and follow up on labs and the outcomes of my recommendations. I am a member of the interdisciplinary care plan team which meets three times a week to develop specific care plans which the staff follows to provide quality individualized care for each resident. Copies of all lab work are sent to the pharmacy daily allowing us to follow up on abnormal labs in a timely manner, thereby preventing possible treatment failures or adverse drug effects. Since many of our residents are renally impaired, estimated creatinine clearance is calculated and dose adjustments are suggested when indicated. Like a consultant pharmacist, I am required to review each resident's chart at least monthly and make recommendations to the physicians and nursing staff to improve resident care and to ensure compliance with HCFA regulations. Because Wesley has a full-time certified geriatric nurse practitioner, most of the recommendations are accepted and acted on the same day they are made, thereby improving outcomes and providing cost savings to the residents and the facility. I also provide inservice education to the staff about regulations and pharmacology. All of these tasks along with my daily interaction with the residents and staff provide me a challenging and rewarding work experience.

(l to r) Technician Beverly Banks, Kaye Vass, PharmD, Liz Rittase, RPh, and Cindy Hundley, RPh.

Our largest stumbling block was getting medicines ready for our new admissions because many times the new residents would arrive late in the afternoon with vague and incomplete orders or with orders for medications not stocked. In order to overcome this obstacle, our admissions coordinator faxes the resident's discharge summary directly to the pharmacy from the hospital. This allows us to review the resident's orders, and with the help of the geriatric nurse practitioner, clarify vague or incomplete orders. In the case of items not stocked, the nurse practitioner is usually willing to change the order to something we do carry. Since we usually get the discharge summary before the resident leaves the hospital, we can have the preliminary drug orders filled and in the med cart before the resident arrives at Wesley. Of course, this is very beneficial for the resident who arrives at Wesley in pain since his pain medication is readily available to the nurse for administration. Another stumbling block was that for years we worked in an antiquated pharmacy. But as of the first of the year, the pharmacy has been renovated thus making our drug distribution system more efficient.

In February, we will begin precepting pharmacy students enabling them to learn about geriatrics in the long-term care setting. Since we have close working relations with three physicians, we are interested in how the Clinical Pharmacist Practitioner Act might expand our clinical opportunities. At Presbyterian Wesley Care Center, we are committed to providing high quality, cost-effective pharmaceutical care for our residents.❖

About the Author...

Kaye E. Vass, BS, Pharm D, CGP, FASCP, clinical pharmacist at Presbyterian Wesley Care Center, can be reached at kevass@navanthealth.org

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Clinical Corner

Eagle Family Medicine, Guilford College

by Amanda Byrd

Eagle Family Medicine at Guilford College is a general family practice office that has seven physicians, one nurse practitioner and one clinical pharmacist. We are part of a parent organization, Eagle Physicians, that is comprised of 12 individual offices. The role of a clinical pharmacist in the office is to serve multiple functions. Many of the functions involve educating patients about various chronic diseases as well as disease state management and provider education. Currently, patients are seen on an individual basis, but we have been considering group appointments for some issues. Working in the same office with providers allows immediate access to the providers when therapeutic management questions arise or an issue that requires immediate assessment is discovered. By working side by side with the providers we function as a team instead of separate health care providers.

Give specific examples of drug protocols you use.

The drug protocols used include anticoagulation, asthma, diabetes, hyperlipidemia, HTN, and obesity management. Patients are managed following a more general protocol rather than a rigid cookbook type protocol. This is based on the fact that all patients are different and have a different set of needs. I have established a good working relationship with the providers and they trust my therapeutic recommendations, how I implement these, and my decision as to when to consult with them about issues.

"By working side by side with the providers we function as a team instead of separate health care providers."

Diabetes is one of the areas of my practice where I am the most influential. I see all patients who have been newly diagnosed with diabetes (other than Medicare patients who must be educated by an ADA approved facility/group) for education and management of drug therapy if appropriate. Being able to quickly begin the education process for newly diagnosed patients has been one of the aspects most valued by the physicians. I also provide education and management of patients with established diabetes that are not well controlled. We have established the use of a flow sheet to increase compliance with standards of care.

Hyperlipidemia is another major area of contribution. I manage both primary and secondary prevention of cardiovascular disease through medication management, diet, and exercise. We are trying to establish action plans for all patients with asthma including monitoring peak flows and education. All patients requiring anticoagulation are followed with in-house PT/INR and office visits to monitor for adverse effects. If patients require stopping warfarin for some type of procedure, I transition the patient to heparin. Appropriate patients who are obese are managed with or without medication for purposeful weight loss.

What kind of feedback do you get from patients and physicians?

The feedback we have received from patients has been very positive. Most patients are surprised by the fact that there is a pharmacist in the physician's office, but when they learn the function that I serve they agree that it is a very valuable service. The physicians have been pleased with the services and decided that benefits provided to the patients were far greater than the position's initial financial loss. Over time, the volume of patients seen has increased and the services have become self-supporting.

How do you get reimbursed?

Following extensive discussion with other providers in the area, including AHEC, we chose to bill the services provided based on "incident to" rules in Medicare. This utilizes evaluation and management codes (E&M) that are the standard billing codes in health care. This is the same method of billing that physician assistants and nurse practitioners use when they do not have their own Medicare provider number. Typically, the level of service is determined by the amount of time spent counseling the patient, but it can also be based on the degree of physical exam, history, etc., which is how physicians determine the level of service the majority of the time. In my practice, physical exam is typically minimal compared to the amount of time counseling, so in most instances the level of service is determined based on this time. For weight loss management, patients are usually responsible for charges because this service is not covered by most insurance plans. Therefore, we explain this in the beginning and have the patient sign a waiver stating they will pay all charges not covered.

What impact will the Clinical Pharmacist Practitioner regulations have on your practice?

Becoming a CPP will allow for more efficient use of my time with patients because it will eliminate time wasted on obtaining written prescription refills. Otherwise, it will legitimize our current working arrangement.

What steps would someone follow to establish a practice like yours?

This position was created from a rotation during my residency with this office. I was lucky enough to have found a group that was progressive in thinking and open to experimentation. I was willing to donate my time originally to prove the benefits, but the physicians did not need proof and paid my salary from the beginning. Consider working a day or two per week, without being compensated if needed, in order to demonstrate the services you can provide to patients. If you can show outcomes and benefits to patients, you will get paid.

Where are you headed now with your practice?

We are planning to add a dietitian soon which will free up more of my time so I can focus on drug therapy management without neglecting areas of lifestyle that are crucial. This should also provide more free time to work on educating the providers. A new area of interest is pain management, especially focusing on chronic fatigue/fibromyalgia.

In 2001 I plan to take the CDE and BCPS exams.❖

About the Author...

Amanda Byrd, PharmD, is a Clinical Pharmacist at Eagle Family Medicine, Guilford College. She can be reached at 336-294-6190 or am_byrd@yahoo.com

Morris Natural Pharmacy

Describe your overall practice.

Morris Natural Pharmacy is located in rural Waynesville, NC, population 10,000. Our services include dispensing traditional prescriptions, compounding patient-specific products, screening for osteoporosis, hyper cholesterolemia and diabetes, and providing nutritional consultation by appointment.

What unique services do you provide?

Our compounding services are recognized by the Professional Compounding Centers of America (PCCA) and we consult with both physicians and patients to determine the most appropriate OTC and prescription therapies. We offer transdermal medication delivery for hormone replacement therapy and pain and nausea management. We also work closely with hospice to determine optimal modes of medication delivery for palliative care. Other areas of our compounding practice include veterinary compounding for small animals, male andropause, and pediatric dosing issues.

We are a Medica pharmacy. Medica is a company that offers training and necessary equipment for in-pharmacy screening such as the bone mineral density screenings we perform using a Sahara Hologic (heel) machine. This service compliments our HRT compounding and nutritional counseling services. BMD screening is provided by appointment for a fee of $25.00. We also provide cholesterol screening using the Cholestech machine and can recommend natural products for lowering cholesterol and triglycerides. Other screening services include hemoglobin A1c and blood glucose screening for diabetes, and Dermaview screening which detects facial skin damage.

I provide clinical nutritional services by appointment. These consultations are offered for a fee of $60/30 minutes and $100/60 minutes. Initial ten-minute consultations are provided to determine a patient's needs/problems and outline treatment alternatives. Treatments range from diet and exercise to the use of vitamin supplements, many of which are sold only to physicians or pharmacists, herbs, and homeopathic remedies. We see about four patients per week for nutritional consultation.

How did you determine a need for your services ?

We viewed the compounding services as an extension of the limited compounding we had always done. PCCA just brought us up to a higher level of comprehensive services. Aseptic compounding for injectables was not offered in our community so I saw it as a real need and niche for us.

The health and wellness center just made sense as we traveled further into the alternative arena. Preventive health enhancement with screening, dietary supplements, and nutritional counseling all projected the look and feel I wanted our pharmacy to have in our community.

Are you being reimbursed for the services you provide?

Yes, we are being paid by private-pay customers. We do not file claims to insurance companies on behalf of patients at this time.

What lessons have you learned?

- Always listen, listen, listen to the patient.
- Be careful not to overwhelm patients with too many things. Identify the issues you want to address and prioritize them. Then begin to make the needed changes one at a time.
- Identify a system/tool which will assist you with patient follow-up. As the patient list gets longer, it becomes more difficult to keep up with new and established patients and eventually, someone is going to slip through the cracks.
- Use hard copy charts.
- Always recommend the best supplemental regimen for the individual patient, but always consider the cost commitment that the patient is willing and able to make in order to optimize their therapy. Let them tell you what they can afford or what commitment they can make after

looking at your protocol.

If you follow these simple rules you should achieve successful outcomes:

- First, do no harm.
- Treat your patients like family.
- Carry the best products you can find.
- Maintain continuing education at the highest level.

What were your stumbling blocks?

- Finding time to see patients.
- Trying to determine what is considered free counseling? I struggle with where to draw the line and how to communicate this to patients when we have been doing it for free in the past.
- I also struggle with not being able to address the more in-depth questions from patients while I'm behind the counter filling prescriptions, answering the phone and counseling other patients. Briefly trying to answer their questions while doing all these other things doesn't project a professional image. Physical restraints, time, and money to take the pharmacy to the level of practice I want to achieve are limited.

Where are you heading now with your practice?

I would like to move away from a traditional pharmacy dispensing practice, toward a compounding-only practice to compliment the health and wellness center and nutritional consultation. At this point it is difficult since the dispensing practice generates the traffic flow needed to build a client base.❖

About the Author...

Bill Morris, RPh, PA, CCN owns and operates Morris Natural Pharmacy in Waynesville, NC. He can be reached at whmorris@primeline.com

A Year in the Life of a Community Resident

by Valerie Britt

As a pharmacy student approaches the end of a long journey and prepares to enter the world as a pharmacist, he or she may contemplate how to best implement all the skills and knowledge learned over the previous four years. As I made the transition, I realized that the best way for me to begin my career as a pharmacist was to practice in an environment that allowed me to learn and experiment while building a practice foundation. I decided to complete a Community Pharmacy Residency with Kerr Drug, Inc. and Campbell University School of Pharmacy. The residency consists of many different activities, all of which focus on providing pharmaceutical care services in the community pharmacy environment. A very important part of my residency is seeing patients at the Kerr Drug Enhanced Pharmaceutical Care Center (EPCC) in Benson, North Carolina. In the EPCC, pharmacists provide one-on-one patient counseling in a variety of disease states, medication consultation, routine health screenings (blood pressure, blood glucose, lipid panel, bone mineral density, body fat composition, and visual field loss), immunizations, and wellness programs. I have had the opportunity to attend several disease state certificate programs, provide drug information to patients as well as other health care providers, participate in practice development and management from a "corporate" standpoint, become involved in professional organizations, and establish collaborative working relationships. As a method to establish a relationship with area providers, I spend one day a week with a local family medicine doctor. While spending time at the physician's office, I counsel patients with chronic diseases and provide drug information. I also have the responsibility of teaching pharmacy students. I assist in teaching the Nonprescription Drug class at CU with five other residents and will present two lectures in the Women's Health Elective. I also help the EPCC coordinator and my preceptor, Gil Steiner, teach fourth-year clerkship students and first-year pharmacy school students who come to the center. The residents will also be presenting CE programs at various local organizations. As part of a joint effort between Campbell University and Health Magazine, I spent two weeks in San Diego and Phoenix doing bone mineral density testing and providing osteoporosis counseling to people in those communities.

My residency project, "Evaluation of a Diabetes Self-Management Education Program in a Community Setting," is designed to demonstrate the value of a community pharmacist to patients, other pharmacists, prescribers, healthcare payers, and the pharmaceutical industry. During a six-month period I will provide intense education about diabetes to the intervention group of the study. This group's hemoglobin A1C and lipid levels will be compared to the control group of the study, which will not receive intense education from the study pharmacists but will not be denied education from other sources. The funding for this project is provided through an APhA Foundation Incentive Grant for Practitioner Innovation in Pharmaceutical Care. The results from the EPCC will be combined with those of another community resident at Ward Drug Company, Stefanie Ferreri. We will present the mid-term results at the APhA Annual Meeting in San Francisco and at the Southeastern Residency Conference.

I chose to do a residency in order to gain additional experience in pharmaceutical care. I also wanted to gain this experience in a community setting that would allow me to be a link in the continuity of care chain. I believe that my career will benefit from my residency training because of the many different kinds of experiences that I have had (and will continue to have) during this year. I think that the hands-on patient care, in addition to the different rotations that I have completed or will complete, (drug information, North Carolina Association of Pharmacists, Ambulatory Care) will make me a more well-rounded pharmacist.

Community Pharmacy Residencies are the best way to train new pharmacists and prepare them for a job in the evolving world of community pharmacy. Community pharmacy is changing from the dispensing role to a more patient-oriented role. A residency provides an array of experiences that will prepare a new pharmacist for his or her role as a health care provider. I believe it is important to remember how dramatically residencies have changed the practice of hospital pharmacists. Prior to residencies, clinical pharmacy as we think of it today did not exist. Residency programs have the potential for setting the ground rules for new practice environments. Years from now when I look back, I will attribute my career to a strong foundation that was built not only by the "traditional" education that I received, but also by my community pharmacy residency and the experiences I gained during that year. ❖

About the Author...
Valerie Britt, PharmD is a Community Resident with Kerr Drug/Campbell University EPCC in Benson, NC. She can be reached at 919.207.1221.

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- Loss of memory/blackouts
- Withdrawal from friends and social activities
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Performance Changes

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- Increased number of prescription errors
- Increased number of customer complaints
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U.S. Pharmaceutical Promotional Spending Topped $8 Billion in First-Half 2000

Product Samples Account for Nearly Half of Total Promotional Investment

IMS HEALTH recently reported that total U.S. pharmaceutical company promotional spending directed toward physicians and consumers topped $8 billion in the first six months of last year, up 14.3 percent over the same time period the previous year. The distribution of prescription samples accounted for the largest portion of the industry's total promotional investment at nearly 50 percent. The findings were recently published in IMS HEALTH's Integrated Promotional ServicesT (IPS) report, which offers unique insights about the promotion of U.S. pharmaceutical products to office- and hospital-based physicians and hospital pharmacists. IPS monthly reports track promotional activities such as sampling volume, sales contact effectiveness, promotional messages, and advertising reach and frequency. IMS HEALTH is the world's leading provider of information solutions to the pharmaceutical and healthcare industries.

"With direct-to-consumer advertising still stealing the spotlight, the significant investment in drug sampling is somewhat overlooked by industry observers," said Liz Coyle, vice president of Marketing, IMS HEALTH North America. "Pharmaceutical companies rely heavily on sampling to create brand awareness and build product loyalty. Many physicians say product sampling is a key reason why they take the time from their busy schedules to see pharmaceutical representatives."

The retail value of pharmaceutical sampling — the actual dollar amount of pharmaceutical products distributed to office-based physicians by pharmaceutical sales representatives — totaled a record $3.9 billion for January though June 2000, an 8.4 percent increase over prior-period results.

Spending on physician-targeted advertising and face-to-face selling accounted for $2.7 billion of the total promotional investment, a 12 percent rise over first-half 1999 levels. Pharmaceutical companies' investment in direct-to-consumer advertising reached $1.3 billion, a 44.5 percent increase over the previous six-months.

The top five prescription products sampled in the first half of 2000 include Claritin (18 million samples), Allegra (13.9 million samples), Zyrtec (13.4 million samples), Vioxx (13.3 million samples), and Celebrex (11.8 million samples). Four of these five products were also the most heavily promoted to consumers.

Based on results from an online research study conducted earlier this year by IMS HEALTH, physicians said they distribute the greatest portion of their samples - approximately 45.1 percent - to patients over the age of 60. Meanwhile 20.7 percent are distributed to patients between 40-59; 16 percent to patients between 20 and 39; and 18.2 percent to individuals 19 or younger. ❖

Continuing Education

In order to better serve our members NCAP will mail a special CE Supplement only to members who request it. CE is no longer published in the *North Carolina Pharmacist*, leaving more room for news of interest to all readers. As always, Continuing Education is available only to members. Members who would like to be added to the mailing list for CE should contact Teressa Reavis at teressa@ncpharmacists.org or call (800) 852-7343 ext. 27.

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Uniform Prescription Drug ID Card

On July 1, 2000 North Carolina's Uniform Prescription Drug Identification Card statute became effective.

Many Pharmacists and insurers are uncertain as to what data elements a card must contain to be compliant with the statute, and how violations should be reported. The statute is not applicable to all health plans.

There are seven data elements required on covered plans by the statute. They are as follows:

Beginning at the top left margin of the card:

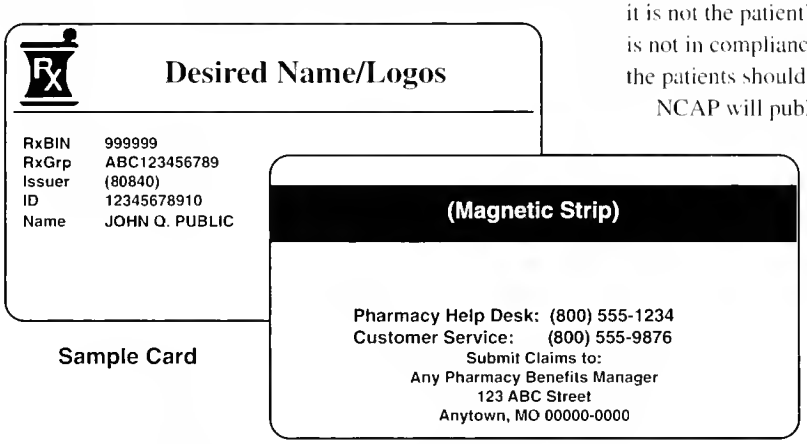
1. The health benefit plan's name and/or logo.
2. The ANSI assigned issuer identification number.
3. The processor control number.
4. The insured's group number.
5. The health benefit plan's card issuer identifier.
6. The insured's identification number.
7. The insured's name.

On the back of the card there are two requirements:

1. The health plan's claims submission name and address.
2. The health benefit plan's help desk telephone number and name.

Insurance companies are not required to issue new cards unless there has been some change in coverage in the previous 12 months. An example would be an addition or deletion of a dependent. A change of this sort would necessitate the issuance of a new card at lease every 12 months. For example, if a child were born to a couple in April a new card would not have to be issued until January of the following year.

On January 1, 2003 all insurers covered must have the required data elements encoded in such a manner as to allow processing or adjudicating of a claim via electronic verification.



Sample Card

There are some ways in which a company is exempted for coverage under the statute.

1. Nothing in the section can require a health benefit plan to violate a contractual agreement, service mark agreement, and a trademark agreement.
2. Health plans that operate their own facilities (example: certain HMO's that operate their own pharmacies).
3. Health Benefit plans that issue a single identification card to its insureds for all services covered under the plan.

Pharmacists and Technicians who encounter cards which appear to be out of compliance with the law should make a photocopy of the card and fax it to the NCAP office at 919-968-9430.

NCAP will report cards that do not comply with the law to the NC Dept. of Insurance, which has the responsibility of enforcing the statute.

The Dept. of Insurance has many remedies available to it for the enforcement of the statute.

Pharmacists should be reminded that it is not the patient's fault that their card is not in compliance and conflicts with the patients should be discouraged.

NCAP will publish a list in *North Carolina Pharmacist* of plans that are in compliance as well as a list of those companies that do not conform to the statute, including those that through a technicality, escape jurisdiction.

Pharmacists can report discrepancies directly to the NC Dept. of Insurance:

Teresa Shackelford
NCDOI
Life Health Division
PO Box 26387
Raleigh, NC 27611
Phone: 919-733-5060
Fax: 919-733-6880

All that is required to report an offender is a legible photocopy of the card.

Ms. Shackelford has suggested that if the volume of the offenders is large, photocopies of the cards should be mailed rather than faxed. ❖

Practice Profile

An Innovative Activity for Innovative Times

by T. Donald Marsh

The issues of infectious diseases and antimicrobial utilization continue to be major challenges to hospital pharmacy departments. Regardless of the hospital size, all are constantly dealing with appropriate antimicrobial use, development of resistant organisms, and how to promote rational antimicrobial selections. Mission-St.Joseph's Health System has an advantage in dealing with these issues with the use of the Antimicrobial Advisory Service, and its pharmacy member, John Phillips, PharmD.

John was instrumental in the formation of the Service and establishing a full-time pharmacist position with the Service. He had seen firsthand what pharmacists could do in the management of antimicrobial use while on the pharmacy staff of Women's Hospital in Greensboro. Pharmacists would retrieve patient culture and sensitivity reports from the laboratory and evaluate whether the antimicrobial therapy was appropriate for each patient. John started doing this same evaluation when he came to MSJ in 1990. In 1993, he was designated as the Infectious Diseases Pharmacist. John would review C&S data and make suggestions to physicians on a part-time basis while continuing his role as a staff pharmacist. Following a presentation to the medical staff describing how one North Carolina institution reduced inappropriate antimicrobial use, institutional bacterial resistance and overall antimicrobial costs by utilizing a pharmacist monitoring system, MSJ pharmacy administration realized the importance of a full-time pharmacist on an antimicrobial service. It successfully placed John in his current position in February, 2000.

John's activities on the Service are very challenging even on a full-time basis. On a typical day, he reviews every patient at MSJ on imipenem, ceftriaxone 2 gm injection, vancomycin, all aminoglycosides, and fluconazole injection. He also screens patients with Pseudomonas cultures, especially those with a ciprofloxacin resistance. He then reviews the medical records of these patients not being seen by the Asheville Infectious Diseases Associates, evaluates appropriateness based on C&S reports, and makes recommendations to the physicians. These recommendations include switching from parenteral to less costly but therapeutically equivalent oral therapy, use of a narrower spectrum agent in place of a broader spectrum agent, or suggest that the physician consult with the ID physicians. John puts all data into a Clinitrends database, indicating his intervention and whether the intervention was successful. He also notes whether his consultation was on his own based on his review of patient data, or whether he was formally consulted by a physician.

This position has put John into interactions with many varied health disciplines, including the housestaff physicians, Infection Control physicians and nurses, laboratory personnel, critical care and general care nurses, and of course, the patients. He works with the lab to generate the annual MSJ Antibiogram, which provides organism and sensitivity data for the MSJ staff. He also works closely with the Sexually Transmitted Diseases (STD) Clinic at the Buncombe County Health Department in Asheville, and the HIV clinic operated by the Asheville Infectious Diseases Associates medical group.

John has collected data on over 600 patients since last February. Using the Clinitrends database, he compiles patient demographics, infection site, C & S data, and the type of intervention and/or consultation he performed. He also indicates if the Asheville Infectious Diseases Associates group was consulted. To date, his interventions on the Service have generated more than $151,000 in documented savings to the Health System. John quickly points out that these savings are only from his involvement with patients on the general medicine floors and does not take into account the critical care patient units. His method of reporting his interventions in the critical care areas is done using a spreadsheet, so overall savings are probably even greater than this figure.

John is a UNC graduate from both the Bachelor's and External PharmD degree programs. In fact, he completed the External PharmD Program while working full-time at MSJ. In addition to his Antimicrobial Advisory Service activities, John precepts UNC PharmD students on their month-long Infectious Diseases Specialty Clerkship, lectures on infectious disease topics at MSJ Inservice presentations, is a member of the MSJ Antibiogram Subcommittee of the Pharmacy and Therapeutics Committee, and is a resource for all health disciplines. He is constantly asked about appropriate therapy, antimicrobial agent comparisons and comparative costs.

John rates his unique position as very rewarding and satisfying. He says that his greatest satisfaction, besides doing something he truly loves, is helping patients get appropriate therapy for their infections. And he is good at it; 75% of his recommendations have been accepted by the physician staff. Because infectious diseases are being identified as factors in more and more noninfectious disorders (e.g., myocardial infarction, attention deficit hyperactivity disorder), he sees his role expanding over the next year. The work is challenging, always dynamic with changing resistance patterns, and fascinating to him. In that regard, he and the MSJ Pharmacy Administration have requested a grant from the Society of Infectious Disease Pharmacists (SIDP) to fund a pharmacy residency position. With a full-time pharmacy resident to work with him, John will expand his activities on this unique service. ❖

About the Author...

T. Donald Marsh, PharmD, FASHP, is Director of the Pharmacotherapy Department at Mountain AHEC in Asheville, NC and Clinical Associate Professor of Pharmacy at UNC School of Pharmacy. He can be reached at 828.257.4468.

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Why Legislation to Recognize Pharmacy Technicians?

After working on the NCAP's Council for Legal & Public Affairs, I would like to present some of the reasons we felt pharmacy technician registration is not only necessary, but also advantageous.

In a time of negatively biased media coverage and concern for public safety, new legislation will facilitate a better understanding of the dynamics of pharmacy. The Pharmacy Technician Bill contains a broad definition of the pharmacy technician allowing flexibility and individual creativity for utilization of the technician in the work place, while acknowledging that not everyone behind the counter wearing a "white coat" is a pharmacist.

One of the reasons commonly stated for the registration of technicians is the expanding role of the pharmacist. The new direction for the pharmacist to do more disease management increases the need to utilize the pharmacy personnel more effectively in the dispensing aspects of pharmacy. This will help augment the public's overall medical care.

Another reason for this legislation is the growing need in the pharmacy work force for competent and reliable pharmacy technicians. With many pharmacy technicians voluntarily acquiring their National Certification, it is only appropriate to recognize the role of the pharmacy technician in all pharmacy settings. This certification provides proof of a technician's advanced level of education. When this high standard is accomplished, the certified technician employment in any pharmacy setting may increase the technician to pharmacist ratio to no more than two to one (2:1). The Draft Bill proposes that the ratio may be expanded if the additional technicians have passed a nationally recognized pharmacy technician certification board exam, or equivalent, approved by the Board of Pharmacy.

With the approval of this legislation the Board of Pharmacy will be able to register and establish guidelines for technicians. Once this legislation is ratified, the Board of Pharmacy can expound and possibly expand the guidelines of pharmacy technicians.

Below is a draft of the bill to be presented to North Carolina's legislators in this session.

PLEASE NOTE: The following is a DRAFT of the Pharmacy Technician Bill as of January 30, 2001. Changes may have been made to the bill after *North Carolina Pharmacist* went to press.

A BILL TO BE ENTITLED
AN ACT TO DEFINE PHARMACY TECHNICIAN, ESTABLISH CERTIFICATION CRITERIA AND PROVIDE FOR REGISTRATION AND TRACKING OF PHARMACY TECHNICIANS.
The General Assembly of North Carolina enacts:

Section 1. Article 4A of Chapter 90-85.3 of the General Statutes is amended by adding two new definitions.

(q1) "Pharmacy personnel" means pharmacists and pharmacy technicians.
(q2) "Pharmacy technician" means unlicensed persons under the supervision of a pharmacist who perform technical functions to assist the pharmacist in preparing and dispensing prescription medications and are or will be subject to the registration requirements of G.S. 90-85.15A. Such persons must have a high school or equivalent degree or be currently enrolled in a program that awards such a degree and shall complete within 180 days of original registration, a training program that includes but is not limited to pharmacy terminology, pharmacy calculations, dispensing systems and labeling requirements, pharmacy laws and regulations, record keeping and documentation and proper handling and storage of medications.
(q3) "The ratio of pharmacy technicians being supervised by a pharmacist shall be no more than two to one (2:1). This ratio may be expanded to three to one (3:1), if at least one (1) of the pharmacy technicians has passed a nationally recognized pharmacy technician certification board exam, or equivalent exam if such exam has been approved by the Board. Upon receiving written approval from the Board, the ratio may be expanded to four to one (4:1) if at least two (2) of the pharmacy technicians have passed a nationally recognized pharmacy technician certification board exam, or equivalent exam if such exam has been approved by the Board.

Section 2. G.S. 90-85.15 is amended by adding a new part 90-85.15A to read:
90-85.15A. Pharmacy Technicians; registration.
Pharmacy technicians shall register annually with the Board of Pharmacy. In addition, the pharmacist manager of any site employing a person defined as a pharmacy technician shall report such employment annually to the Board. In addition, the pharmacist manager of any site employing a person defined as a pharmacy technician shall notify the Board within 30 days of the person's beginning employment. Annual registration will not be required of pharmacy students who are enrolled in a school of pharmacy approved by the Board, pursuant to G.S. 90-85.13.
In accordance with Chapter 150B of the General Statutes and regulations adopted by the Board, the Board may issue a letter of reprimand or suspend, restrict, revoke, or refuse to grant or renew the registration of a pharmacy technician.

Section 3. G.S. 90-85.21. is amended to read as rewritten:
(a) In accordance with Board regulations, each pharmacy in North Carolina shall annually register with the Board on a form provided by the Board. The application shall identify the pharmacist-manager of the pharmacy and all ~~pharmacist~~ pharmacy personnel employed in the pharmacy. All pharmacist-managers shall notify the Board of any change in ~~pharmacist~~ pharmacy personnel within 30 days of such change.

Section 4. G.S. 90-85.24 is amended to

read as rewritten:

The Board of Pharmacy shall be entitled to charge and collect not more than the following fees; for the examination of an applicant for license as a pharmacist, one hundred sixty dollars ($160.00) plus the cost of the test material; for renewing the license as a pharmacist, one hundred ten dollars ($110.00); ~~for renewing the license of an assistant pharmacist ten dollars ($10.00)~~; for registration of a pharmacy technician as required under G.S. 90-85.15A, twenty-five dollars ($25); for licenses without examination as provided in G.S. 90-85.20, original, four hundred dollars ($400.00); for original registration of a pharmacy, three hundred fifty dollars ($350.00), and renewal thereof, one hundred seventy-five dollars ($175.00); for annual registration as a dispensing physician under G.S. 90-8521(b), fifty dollars ($50.00); for annual registration as a dispensing physician assistant under G.S. 90-18.1, fifty dollars ($50.00); for annual registration as a dispensing nurse practitioner under G.S. 90-85.21(a), twenty-five dollars ($25.00); for a duplicate of any license, permit, or registration issued by the Board, twenty-five dollars ($25.00); for registration to dispense devices, deliver medical equipment, or both, three hundred dollars ($300.00) per year. All fees shall be paid before any applicant may be admitted to examination or the applicant's name may be placed upon the register of pharmacists or before any license or permit, or any renewal thereof, may be issued by the Board. (1905, c. 108, s. 12; Rev., s. 4478; C.S., s. 6657; 1921, c. 57, s. 3; 1945, c. 572, s. 3; 1953, c. 183, s. 1; 1965, c. 676, s. 1; 1973, c. 1183; 1981, c. 72; c. 717, s. 3; 1981 (reg. Sess., 1982), c. 1188, s. 2; 1983, c. 196, s. 8; 1987, c. 260; 1987 (Reg. Sess., 1988), c. 1039, s. 4; 1993 (Reg. Sess., 1994), c. 692, s. 3; 1997-231, s. 1.)

Section 5. This act becomes effective on January 1, 2002.

Logic should tell us that the administration of any registration would have a cost, so a fee will be included in this bill. At this time a $25 fee is under consideration.

In the continuing evolution of pharmacy, this bill is a positive step towards advancing and improving the role of pharmacy technicians. To this end, I hope that you will support the passing of this legislation. ❖

About the Author...

Faye M. Elliatt, CPhT is the Pharmacy Office Manager in Guilford County. She can be reached via e-mail at Fayee@aol.com.

Pharmacy Technician Bill Talking Points

I. Facts:

✔ *Retail prescriptions dispensed in the United States rose by 44% between 1992 and 1999—from 1.9 to 2.8 billion while pharmacy school applications declined 33% in 1999 compared to 1994.

✔ *The number of vacant full and part-time drug store pharmacist positions nationally rose sharply from about 2,700 in February 1998 to nearly 7,000 by February 2000 (vacancies are expected to continue to grow).

✔ *The estimated annual number of prescriptions filled by each retail pharmacist grew from 17,400 in 1992 to 22,900 in 1999, an increase of 32%.

*According to a report by the U.S. Department of Health and Human Services entitled, The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists. Please note: this report is available at http://bhpr.hrsa.gov/healthworkforce/pharmacist.html

II. Pharmacy Technician Registration Bill is necessary because:

(a) The Board of Pharmacy and Pharmacists need a tracking system to identify technicians who have been disciplined or terminated for violations such as theft, drug addiction, incompetence, etc.

(b) The public and Pharmacists need technicians who are trained and knowledgeable of pharmacy terminology, pharmacy calculations, dispensing systems and labeling requirements, pharmacy laws and regulations record keeping and documentation and proper handling and storage of medications.

(c) Pharmacists depend on technicians to perform repetitive manual tasks to allow pharmacists more time for patient counseling.

(d) Establishes a safe ratio of technicians supervised by a pharmacist and allows the Board of Pharmacy the authority over petitions for variance.

Call for Tech Practice Forum Committee Members

As a pharmacy technician, you are a vital part of the health care team of the 21st century. Your role has expanded and will continue to change over the next few years. You can help shape these changes through your involvement with the newly formed NCAP Technician Practice Forum committees. There are many opportunities to use your expertise and talents by serving on a committee. Below is a list of the committees and their charges for the upcoming year. If you are interested in serving on a committee, please contact the chair and notify Linda Goswick, NCAP Executive Assistant (800-852-7343 / linda@ncpharmacists.org). I urge you to consider serving as we all are responsible for the future of our profession.

Education Committee

- In conjunction with the NCAP Education Council, plan the next 3 technician CE meetings (March 2001 in Hickory; September 2001 in the eastern part of NC; and October 2001 in Greensboro)
- Investigate a joint venture with Community College technician programs
- Investigate the offering of a review course for the certification exam

Contact: Marion K. Keener, CPhT Chair
phone: 704.489.0216, e-mail: mkkcpht@hotmail.com

Legal & Regulatory Committee

- Encourage technician participation in Pharmacists' Afternoon in the Legislature
- Educate technicians and pharmacists regarding the technician bill

Contact: Faye Elliott, Chair
phone: 336.373.3388, e-mail: fayee@aol.com

Nominations Committee

- Determine what officers the Technician Practice Forum needs
- Develop the process for nominating and electing the officers and representatives to the NCAP House of Delegates
- Review and revise the General Administrative Regulations and Rules of Procedure for use by the Technician Practice Forum

Contact: Dorothy Cowan, Chair
phone: 910.577.2811, e-mail: jamin4jesus@ncfreedom.net

Marketing and Membership Committee

- Oversee the "Tech Talk" column in the NCAP journal
- Develop a technician section of the NCAP website
- Promote technician membership in NCAP
- Investigate establishing a technician mentorship program
- Promote the role of the pharmacy technician to the public

Contact: Sandy Wheeley, Chair
phone: 336.578.9606, e-mail: Wheel029@mc.duke.edu

Campbell U. School of Pharmacy Update

The new semester at Campbell University has begun with a wave of enthusiasm. The Annual Apothecary Ball, held on January 13th at the Brownstone Inn, was a huge success with over three hundred students, staff, faculty, and guests looking their best.

Election of new officers for the Pharmacy Student Executive Board has provided fresh, vibrant student leadership for the new year. The new officers are:

President:	Chad Riggs
Vice-President:	Laura Williford
Secretary:	TraceyHoward
Treasurer:	Martie Firebaugh

The annual Career Day on January 19th brought thirty-two employers to campus to interview potential Pharmacists from the next graduating class of ninety students.

Completion of our new building, The Pharmaceutical Sciences Research Institute, has provided valuable GMP and GLP-certifiable space for future drug development projects. As we head into the new millennium, we remain excited about pharmacist education in Buies Creek.

Campbell University's Career Day brought thirty-two employers to campus.

We've Given A Whole New Meaning To The Advantage Of Full Service.

Independent pharmacies in the Tarheel State now have a tremendous opportunity to receive the ultimate in personal service and get a jump on the competition by joining the CPN-Smith Advantage Program. The CPN-Smith Advantage gives members of the Carolina Pharmacy Network several competitive advantages including unique purchasing opportunities.

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NCAP Auxiliary Providing Support

The North Carolina Association of Pharmacists office in Chapel Hill is receiving a face lift, thanks to the NCAP Auxiliary whose main project this year is to refurbish the beautiful rose beds that surround the building. The Auxiliary has contracted with Witherspoon Rose Culture company to plant additional bushes and maintain the rose beds.

The Auxiliary also purchased a much needed fax machine and color printer for the NCAP office. These items are greatly appreciated and have created a more efficient working environment for the staff.

Membership dues for 2001 are $25. Membership is good January 1 through December 31. Dues may be sent to:

Shirley O'Neal
325 Water Street
Belhaven, NC 27810

NCAP Auxiliary Executive Board for 2001:

Vivia Creech, Co-president
Smithfield, NC
Lib Fearing, Co-president
Manteo, NC
Margaret Randall, 1st Vice President
Lillington, NC
Shirley O'Neal, 2nd Vice President
Belhaven, NC
Rebecca Work, Treasurer
Chapel Hill, NC
Peggy Eckel, Recording Secretary
Chapel Hill, NC
Sybil Skakle, Corresponsing Secretary
Chapel Hill, NC
Jean Morse, Historian
Raleigh, NC
Dot Moose, Parlamentarian
Mt. Pleasant, NC
Rose Boyd, Advisor
Kenly, NC
Karen Campbell, Advisor
Chapel Hill, NC
Erie Cocolas, Coordinator
Chapel Hill, NC

The NCAP Auxiliary is spearheading an effort to refurbish the rose gardens that surround the Institute of Pharmacy. (l to r) Margaret Randall, Lib Fearing, Karen Campbell, Ruby Creech, Jean Morse, and Vivia Creech.

A new fax machine and a color printer were recenlty purchased by the Auxiliary and donated to the NCAP office. Pictured with the new fax machine are (l to r) Jean Morse, Sybil Skakle, Lib Fearing, Peggy Eckel, Margaret Randall, and Erie Cocolas.

Form Available to Report Third-Party Hassles

NCAP is leading an initiative to collect information about the prescription processing hassles facing retail pharmacists today, but we need YOUR HELP! By visiting the NCAP website at www.ncpharmacists.org, you will find a simple, one-page form that you can print out. This form is designed for pharmacists, technicians, and consumers to fill out and fax back to NCAP. We will compile the information, post it on our website, and report it to the public and third-party payers.

Please share this form with other pharmacists and technicians, whether they are NCAP members or not. Remember, it will take all of us working together to make a difference...if we don't hear from you, we'll have to assume that your daily practice isn't affected by third-party hassles!

Thank you for taking the time to provide this valuable information to us.

Pharmacy Technician Professional Liability Available

Pharmacists Mutual Insurance Company of Algona, Iowa would like to recognize and congratulate the North Carolina pharmacy technicians who have received their certifications. We would also like to take this opportunity to remind all technicians that their duties and visibility to the public may result in increased exposure to professional liability claims.

Recognition of this exposure prompted Pharmacists Mutual, the industry leader in insurance programs for pharmacists, to introduce the first Individual Pharmacy Technician Professional Liability Insurance Policy in 1996. This was the first policy developed which provides coverage 24 hours a day for professional acts performed by a pharmacy technician. It is an excess policy designed to provide coverage after the employer's underlying policy limits are exhausted, if there is a problem with the employer's insurance coverage, or if the employer's policy does not provide coverage.

This unique coverage is now available with a first year premium of $45 (thereafter, only $75 per year) for $1,000,000 of protection for each occurrence and up to $3,000,000 per year aggregate. To qualify for the coverage, a pharmacy technician must be registered, licensed, certified, or have completed an approved pharmacy technician or qualifying continuing education program. Pharmacy technicians who qualify for this policy are eligible for dividend savings (dividends cannot be guaranteed), as well as other Pharmacists Mutual coverages, such as auto, homeowners and life. For more information on this program, please call 800-247-5930, ext. 711 or visit our website: www.phmic.com (this is not a claims reporting site).

Currently licensed in 33 states, Pharmacists Mutual has been providing exceptional products and professional service to the pharmacy profession since 1909.

Register for Pharmacists' Afternoon in the Legislature

This is your chance to be heard! NCAP and the North Carolina Retail Merchants Association are sponsoring Pharmacists' Afternoon in the Legislature on Tuesday, March 13, 2001. Please take this opportunity to talk with your legislators about important pharmacy issues. The registration fee is $25. Please call the NCAP office at 800.852.7343 for a registration form. A briefing will be held from 2:00 to 3:00 pm in the Auditorium of the North Carolina Museum of History and from 3:00 to 5:30 pm pharmacists will meet with legislators. A reception for attendees and legislators will follow in the lobby of the museum from 5:30 to 7:00 pm. Please schedule appointments with your legislators by calling the State Senate at 919.733.7761 or the House of Representatives at 919.733.7760. For more information visit the NC General Assembly website at www.ncga.state.nc.us.

PTCB Announces Winners

The Pharmacy Technician Certification Board (PTCP) announced the winners of the 2000 Innovations in Pharmaceutical Care Awards at the ASHP Midyear Conference in Las Vegas, NV on December 4. Five winning teams were chosen for their innovations in pharmaceutical care. Among the winners were Michelle Giesler, PharmD, Michelle Kuhrt, CPhT and Wendy Rycek, CPhT of Duke University Medical Center in Durham, NC. This team re-engineered pharmacy work functions. The new responsibilities for clinical pharmacy technicians allowed pharmacists more time to focus on patient care.

Each of the five winning teams received a cash award of $1,000 to be shared equally by the pharmacist and certified pharmacy technician, and a framed certificate. 2001 Award applications are now available at www.pctb.org. The deadline is September 1, 2001.

NCAP Mentorship Program

The NCAP Mentorship Program gives Mentors the opportunity to share their valuable experience with Mentees, who in turn, gain from the knowledge and guidance of an active member of the association. NCAP is seeking participants in the program which matches Mentees with Mentors, and is designed to:

- Encourage personal and professional growth of "new" members who may serve as future leaders in the organization, and
- Allow members an opportunity to become better acquainted with organizational activities and services through one-on-one interaction with a mentor.

A *Mentor* is a member who serves on a Council or Practice Forum and has been in practice for at least five years. A *Mentee* is any member (pharmacist, student, technician) who would like a recognized leader to guide and encourage involvement in NCAP events and facilitate networking.

If your are interested in participating in the Mentorship Program call the NCAP office at 919.967.2237

Has Your Address Changed?

Keeping track of our members is important. Please notify NCAP if your street address, e-mail address or phone number has changed. Call 800.852.7343 or e-mail teressa@ncpharmacists.org to report any changes.

ASHP Survey Reveals Snapshot of Medication Use in the U.S.

A new survey reveals that over half (51%) of American adults take two or more medications each day. In addition, almost half of Americans (46%) take at least one prescription medicine each day, while more than a quarter (28%) take multiple prescription medications daily. The survey of 1,000 Americans, commissioned by the American Society of Health-System Pharmacists (ASHP), focused on consumers' use of prescription and non-prescription medications, including herbal supplements and vitamins.

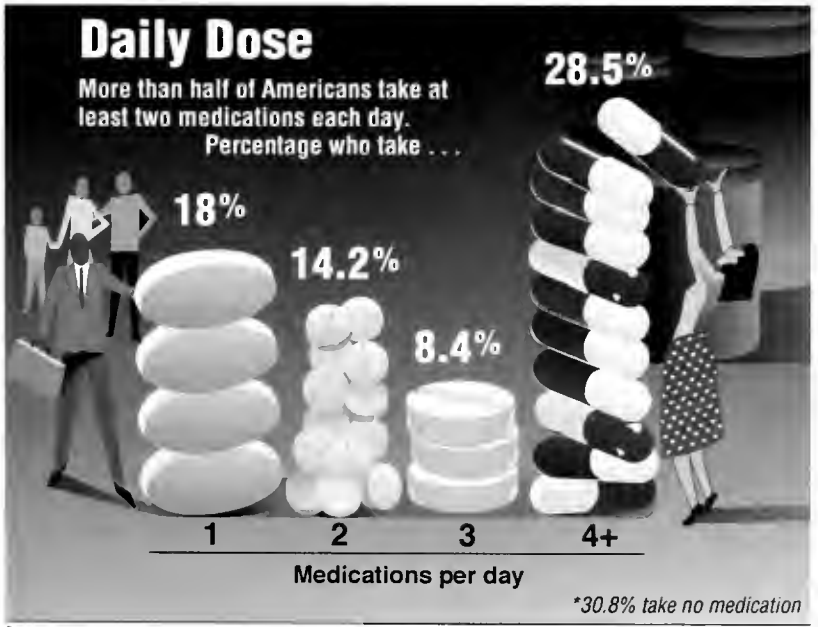
The survey, which also probed for information about whether hospital patients report medication use to health care providers, revealed that nearly ten percent (8%) of respondents do not inform hospital personnel about medications they are taking. Most respondents who report their medication use do so by telling a doctor or nurse (39%) or both (18%). Only three percent of respondents said they bring their medications with them to the hospital.

Rates of prescription medication use were highest among older Americans. Seventy-nine percent of respondents age 65 and over reported taking one prescription medication each day compared with respondents age 55 to 64 (63%), age 45 to 54 (52%), and age 44 years or younger (28%). Americans over age 65 who take prescription medications take an average of four each day.

Among respondents who reported use of a prescription medication in the past week, the majority (61%) indicated the medication was for a long-term health condition. Twenty-four percent said they are treating a recurring health problem, while 10 percent indicated they are treating a short-term, acute health condition.

Along with prescription medications, consumers are also taking multiple non-prescription drugs, herbal supplements, and vitamins. According to the survey, nearly two-thirds (58%) of respondents reported taking an average of two non-prescription medications in the past week. Nearly one-third indicated they take an average of two non-prescription medications each day.

When asked about use of herbal supplements or vitamins, one third (39%) reported taking an average of four in the past week. More than one third (40%) reported taking an average of two herbal supplements or vitamins each day. ❖



Source: The American Society of Health-System Pharmacists (ASHP)

2001 Calendar

March 1-2: ***Annual Winter Meeting*** Greensboro Marriott Downtown. Make plans now to attend! Topics include Pain Management Issues, Medical/Legal Issues of Narcotic Use, Pharmaceutical Care of Common Problems in the Elderly, Antibiotic Issues in Trauma and Critical Care Patients, Asthma Patient Management, Update on the Management of Congestive Heart Failure, and Drug Therapy Management for the Stroke Patient.

March 13: ***Pharmacists' Afternoon in the Legislature***, 2:00 pm, NC Musuem of History, Raleigh. This is your opportunity to talk with your Legislators about important pharmacy issues. To register for PAL call NCAP at 1.800.852.7343.

March 29-31: ***Annual Carolina Regional Conference for Consultant Pharmacists*** Charlotte University Hilton. Topics include Low Molecular Heparin Switch to Warfarin, Chronic Wounds with Inclusion of Nurses, Assisted Living, Infectious Disease Review, Advances in the Treatment of Multiple Sclerosis, Breast Cancer Prevention, Advanced Interpretation of Lab Values, Neurology of Addiction, Drug Diversion, Falls, Alzheimer's Disease and Insomnia.

October 29-31: ***NCAP Annual Pharmacy Convention and Annual Carolina Seminar*** Sheraton Four Seasons, Greensboro. Topics include Pharmaceutical Approaches to Infectious Disease Therapy, Medication Errors, Prevention and Detection.

Please visit the NCAP website at www.ncpharmacists.org for more information on upcoming meetings and events.

North Carolina Pharmacist

Volume 81, Number 2 ...applying drug knowledge to improve health Spring, 2001

Communicating the Value of Pharmacy to the Public

North Carolina Association of Pharmacists PR Toolkit

"Communicating the value of the pharmacist and the role of the pharmacy technician to the public."

The NCAP Three-year Strategic Plan provides direction for developing our Annual Implementation Plan (AIP). The 2001 AIP includes twelve goals and thirty-eight planned actions to achieve these goals. However, the NCAP Board selected "...mmunicating the value of pharmacy to the public" as top priority for 2001. Both pati...e who pay for healthcare services must become educated about your value ...icate this than the one who provides the care. There are indicati... achieving provider status and reimbursement for def...ore recognition by the public, payers and thos...r, radio or television reporters to produc...you can create a win-win situation for ...or risk losing funding for operation...

Relationships ...letting your patients and community ...macist.

Communicating ...

...esident

1. Q&A Patient Flyer
A one-page flyer containing va...
commonly asked questions in ar...
medication safety and health ben...
pharmacy's name, make copies, a...

2. Tips for Working With ...
Carrying out our Str...
ontains tips ...
ditor ...

Facts You Should Know About Rx Drugs

from the North Carolina Association of Pharmacists & (insert your pharmacy name here)

Q: What does a pharmacist really do?

A: Pharm... do much more ... pills. Pharmacists are medication-use experts with at least five years of highly spe... education, and ... have completed doctoral degrees (Pharm.D.) in pharmacy. Pharmacists are trai... to ... you about prope... use. They check for harmful drug interactions and consult with doctors, nurse... healthcare professi... to ... sure your drug therapy is safe and Pharmacists are assisted by pharm... technicians who have ... and often certified, to hel... process claims.

...st so much?

...n drugs. Drug prices are based on rese... marketing is growing much ...vertising is proje... agazin...

Seventy-Five Years Ago, We Were An Independent Pharmacy, Too.

Our roots as an independent pharmacy go back three-quarters of a century, when the first Smith pharmacy was founded. We began wholesale distribution in 1945 and ended dispensing perscriptions. Today, we serve hundreds of independent pharmacies across the Southeast.

Since we began as an independent pharmacy, we know how your business operates from the ground up. Smith Drug carries a full inventory of pharmaceuticals, OTC and HME items, so we are a single source for everything you need. But perhaps the single factor that separates Smith Drug from the others is our level of service to our customers.

We want you to think of us like your customers think of you. They choose an independent pharmacy for important reasons – the same reasons you should consider when choosing your wholesaler.

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North Carolina Pharmacist

Volume 81, Number 2 ...applying drug knowledge to improve health Spring 2001

Inside

North Carolina Association of Pharmacists
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Chapel Hill, NC 27516
phone: (919) 967-2237
fax: (919) 968-9430

William L. Harris, Jr.
President, NCAP

Dear NCAP member,

The value of patient counseling by pharmacists is receiving renewed attention. Healthcare statistics indicate that medication compliance continues to be a serious problem. Literature articles report that up to 50% of prescriptions are not taken as prescribed due to misunderstanding, failure to follow instructions, not refilling or other patient problems. In one study for patients over age 60, patients took their medications incorrectly in 59% of cases. Non-compliance results in millions of lost workdays, lost wages, increased treatment costs and decreased quality of life for the patient and the family. Non-compliance accounts for 10% of all hospital admissions, 23% of nursing home admissions and may result in 125,000 deaths annually in the U.S.

In January 2000, the National Council on Patient Information and Education (NCPIE) reported that its mission is "ensuring the appropriate use of medicines." The proposed solution to non-compliance and medication misuse is to "improve communication about safe, effective medication use," a goal seemingly taken from the mission of pharmacy. Pharmacy organizations partner with NCPIE each year in programs, such as Talk About Prescriptions Month. However, with only 50% compliance, patient counseling and communication about medications must be a focus every month, not just once a year.

Prescription data indicates that approximately 3.15 billion prescriptions were dispensed in the U.S. in 2000. The number or percentage of patients that pharmacists counseled last year is unavailable. There are signs, however, that not enough patients were counseled. At the Board of Pharmacy Leaders Forum in February 2001, Board members reported that in all recent cases in N.C. involving patient injury from a dispensing error, the adverse drug event could have been discovered and avoided if the pharmacist had counseled the patient. This stresses the importance of pharmacists finding the time and making the effort to counsel all patients at the point of care.

Pharmacy's mission is to help patients make the best use of medication, the basic meaning of pharmaceutical care. Patient counseling at the time of dispensing or discharge from hospitals, nursing homes or other healthcare facilities is a great opportunity to form and enhance relationships with patients. Most patients have questions about their medications, the side effects, how to know if the medication is working and what to do if problems arise. Our challenge is to provide the patient with enough information about their medications and encourage them to become informed and responsible for their health while instilling the importance of compliance with their medication regimen.

What can pharmacists do to improve medication compliance?

- Increase the number of patients who receive counseling at the point of dispensing or discharge from healthcare facilities. Stress the importance of compliance to the overall goals of the medications.
- Provide patients with both verbal and written information about their medications.
- Monitor medication usage by your patients. Reminders and other compliance aides reduce the incidence of non-compliance.
- Work with other healthcare providers to improve the accuracy of patient profiles and medical records. Researchers in one study found a 76% discrepancy rate between recorded medication records and medications actually taken by patients (prescription and OTC).

As we pursue provider status and payment for cognitive services, we must utilize our opportunities to help our patients achieve desired outcomes from medications through patient education, monitoring drug therapy and enhanced compliance. In Project ImPACT, patients with hyperlipidemia had improved outcomes and medication compliance improved to 94% through active patient education and monitoring by pharmacists. Numerous other studies have documented the negative patient outcomes of non-compliance for patients with diabetes, hypertension, asthma, organ transplantation, epilepsy and other chronic diseases.

Pharmacists enjoy the reputation of drug experts and were recognized in the 1999 Institute of Medicine report as important sources of drug information and primary health care providers. The January 2000 GAO report on adverse drug events stated that increasing the role of pharmacists in monitoring drug therapy improves patients' compliance with their medications. Our challenge is to meet this need and increase our visibility and value to the public.

"Communicate before you medicate" is not just a slogan for one month or special events. It is our professional mission every day, for every patient.

Sincerely,
William L. Harris, Jr., RPh, President

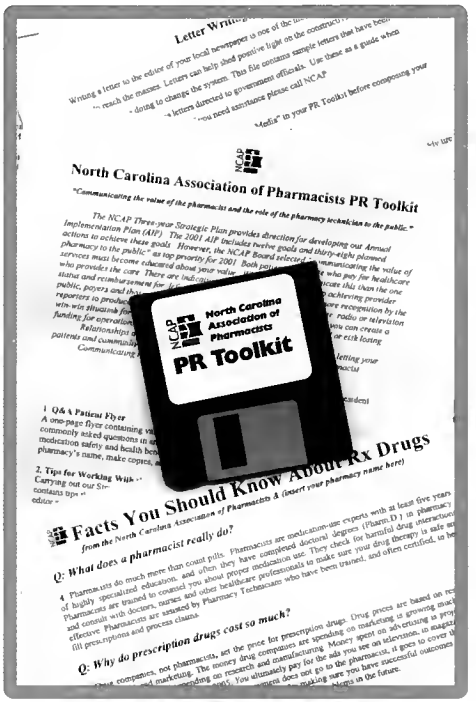
...applying drug knowledge to improve health

How Do You Improve Patient and Community Relations?

Use the New NCAP PR Toolkit

The North Carolina Association of Pharmacists sponsored a Leadership Development Conference March 22 at the Institute of Pharmacy in Chapel Hill. More than fifty pharmacists and technicians learned basic public relations skills, reviewed the new NCAP PR Toolkit, and charted their own course of action to assist with NCAP's 2001 Annual Implementation Plan, "Communicating the Value of the Pharmacist and the Role of the Pharmacy Technician to the Public."

Speakers at the Conference included C. Edwin Webb, Director of Government and Professional Affairs at the American College of Clinical Pharmacy in Washington DC, and Ellen Wilcox, Director of Public Relations at the American Society of Health-System Pharmacists in Washington, DC. Webb's presentation, "Advocacy for Clinical Pharmacy: Priorities and Strategies," was followed by "Public Relations 101" presented by Wilcox. After reviewing the new NCAP PR Toolkit, break-out groups were formed. The groups were asked to develop a list of things individuals can do with NCAP to implement the PR Plan, and a list of things they can do in their own practice setting to help implement the plan. Each attendee left the conference with lists of ideas and strategies for carrying out NCAP's goals.



The NCAP PR Toolkit is designed to help pharmacy professionals improve patient and community relations by using one or more of the tools provided.

NCAP PR Toolkit Contents:

Q&A Patient Flyer

This one-page flyer contains valuable information for consumers. The flyer supplies answers to commonly asked questions about the role of pharmacists and pharmacy technicians. It is written in an easy-to-read format that dispels rumors and offers tips on medication safety and health benefit plans. Simply customize the flyer by inserting your pharmacy's name, make copies, and distribute it in Rx bags and on counter tops, or enlarge to poster size for display.

Tips for Working With the Media

Carrying out our Strategic Plan for 2001 means making frequent contact with the media. This list contains tips that will help you prepare for such an event whether you are writing a letter to the editor or appearing on a local talk show.

NC Media Contacts

Getting your message to the right person is critical. This list contains contact information for major newspapers and television stations across North Carolina. If your local media is not listed and you need assistance, please contact the NCAP Office of Media Relations.

Letter Writing Guide

This file contains sample letters written by pharmacy professionals and sent to newspapers and elected officials. You can use these letters as a guide when constructing your own letter.

NCAP would like to know what you are doing in your community to communicate the value of pharmacists and pharmacy technicians to the public. Let us know how you're using the PR Toolkit. Please forward a copy of your published letters or personal PR plan to the NCAP office so we can share this information with other members. ❖

To receive your NCAP PR Toolkit call the Office of Media Relations at 800.852.7343. The Toolkit can also be found on the NCAP website at www.ncpharmacists.org

Guest Editorial

Perspectives on Troubling Times

In my travels around the state and the nation, I encounter questions from dispensing pharmacists who are stressed and concerned about where our profession is going. Here is a sample, along with my perspective, reflecting an economic point of view. The concerns are real, and the answers are not always neat and tidy. Here's my view.

Why have dispensing fees so low, and what can be done about it?

The simple answer is, "market forces at work!" Like it or not, prescriptions are increasingly seen as a commodity,

by Dale B. Christensen

particularly by large purchasers. A single patient does not have purchasing power, but an insurer does. From a purchaser's perspective, why should (s)he pay a $5.00 dispensing fee when other insurers are paying, say, $3.00, or as little as $1.50? As the insurer's number of covered lives increase, bargaining for the best price becomes increasingly important. Consider that if the insurer processes 10,000 prescriptions per year, the savings for achieving a $1 lower dispensing fee is $10,000. For 1,000,000 prescriptions, the savings is $1,000,000. Even for a manager sympathetic to the plight of pharmacists, it is difficult to defend not saving one million dollars to superiors. Sometimes bonuses are tied to performance, and this is one such measure.

We witness this practice repeatedly in and outside the world of pharmacy and pharmaceuticals. Multi-source product manufacturers must offer lower prices to sell to a managed care account that can move market shares in the direction of their product. Quantity discounts also drive lower prices. Competition has also forced a steady erosion of wholesalers' "up charges" to pharmacies to levels approaching zero over the past two decades. Even among sole source products, price erosion exists, at least at the retail level. Consider, for example, newspaper and web site ads for Viagra. As one example outside of pharmacy, consider what has happened to long distance phone rates.

While this is typical marketplace behavior, it rarely exists in an ideal way, because there are rarely purely competitive markets. Market disparities occur when there are unequal numbers of buyers and sellers, as is the case in the third-party dominated market for prescriptions today. A monopoly exists when there is one benefit seller (a health insurer) and many buyers (pharmacies) in a market. In many small towns, a single large employer or insurance plan effectively controls the market. More often, we see a situation where there are few large sellers (e.g., Blue Cross, State Health Plan, Medicaid) and many buyers (oligopoly). In either case, it is an economically unbalanced and unfair situation from the perspective of the buyer (pharmacy).

How can pharmacies stay in business with dispensing fees as low as they are?

The answer is, they can't in the long run but they often try. Most pharmacies are in a tough situation. The old saying, "I may be losing money but I am making it up in volume" is painfully true today. Dispensing fees are so low and the discount from AWP so close to cost that some pharmacies are actually losing money when they fill prescriptions. There are several reasons why this seemingly foolish practice persists. First, many pharmacy managers don't know their true labor cost to dispense a prescription. Nor are they fully aware of what their true drug acquisition cost is, expressed as AWP- *something*.

Second, even if they know, managers may opt to fill prescriptions up to the point of full capacity – a newly opened pharmacy, for example. The economic rationale for this decision is rooted in marginal cost analysis. As long as you generate enough gross margin to cover variable costs, any additional amount is profit in the short term. We see this principle in action when firms like Priceline.com sell airline seats to you at rock bottom prices for last-minute flights. Better to have the seat filled, as long as the sale at least covers the cost of fuel plus meals and supplies. A related reason is inertia. The lost dispensing volume resulting from a decision not to accept may be welcome relief to an overworked pharmacist, but if it represents a substantial portion of the core pharmacy business, the downsizing may be too onerous to consider.

The third reason is the thinking that while profit margins may be non-existent on prescriptions, the pharmacy benefits from other purchases the patient makes while in the pharmacy, either at this visit or by more frequent visits to the pharmacy over time. Obviously, this works much more to the advantage of chains, food stores, or mass merchandisers than to independents or clinic pharmacies.

Pharmacists have absorbed the losses from a single discounted plan by shifting the cost burden to another group, such as the private pay patient. But the increasing third-party coverage has shrunk this patient pool and, in effect, higher paying insurance programs now bear the burden. As large insurance plans ratchet reimbursements down to the level of the lowest payer in a marketplace, we will witness the proverbial straw (log in this case) that broke the camel's back. In North Carolina, this will probably be exemplified by the Medicaid program, the State Health Plan, or both.

What can be done?

Just say NO seems to be the simplest but most difficult answer, especially for a small independent or chain. No one will notice if small providers just say no. However, among large chains if one says no and the others say yes, a tremendous market shift can occur. It is difficult to justify if you are a regional chain manager. The hope is that a sufficient number of pharmacies say no to disrupt access to services, but pharmacies are legally barred from collectively planning such a move.

The response of most managers has been to focus on lowering dispensing costs by redistributing demand, using technicians, or using technology (dispensing machines). This means more prescriptions pass through a supervising pharmacist per hour of the day, adding to job stress. As we are well aware, attracting pharmacists to work in such an environment is difficult and has been a factor in wage inflation.

A final response is to plead the case for equity, fairness, and medication safety to the appropriate deliberative decision-making body. The legislature serves in this capacity for the State Health Plan and Medicaid. An argument of unfairness can be made if it can be shown, for example, that other health professionals' fees have not been similarly reduced.

Where will it all end?

Just like the stock market of late, the crazy spiral of pharmacist shortages, sky-high wages, and terrible working conditions must inevitably end, probably through technical efficiency and automation. Dot-coms aren't the answer, but click and mortar operations continue to thrive. It may very well take acceptance of that last insurance program's low dispensing fee deal to finally cause a change. At the point where sufficient numbers of pharmacies just say no or close their doors, policy makers may take notice and remedy the situation by rescinding at or below cost offers. The travesty is the irreparable damage done to many small pharmacies that serve their neighborhoods so well, as well as to the patients they serve.

What else can be done?

We need to accept, albeit begrudgingly, the payer perspective that the prescription is a commodity. Pharmaceutical services, on the other hand, are not. I strongly recommend pharmacists develop and build a practice on non-dispensing services or ancillary services. Call them cognitive services; pharmaceutical care services, pharmaceutical services or disease management services. These include durable medical equipment and compounding. Based on the summary results of the North Carolina pharmacy practice survey recently published in this journal, it is comforting to note that increasing numbers of pharmacists are doing just that. Services must be aggressively marketed directly to patients, employers, and insurance companies, probably in that order. To provide greater recognition and acceptance by third-party payers, pharmacists must join together to offer standardized disease management services in a region. If a service opportunity exists in your area as a demonstration project, do all you can to make it a success. I fervently believe it is only a matter of time before such services become recognized, valued, and compensated by an ever-growing constituency. ❖

About the Author...

Dale B. Christensen, RPh, PhD, is a Professor and Chairman of the Pharmaceutical Policy and Evaluative Sciences Department at the UNC-CH School of Pharmacy. He can be reached at dale_christensen@unc.edu

Pharmacists' Afternoon in the Legislature Exceeds All Expectations!

(l to r) Al Cole, RPh, Senator Robert Soles, Jr. (D-18th District), Senator Frank Winston Ballance, Jr. (D-2nd District), and North Carolina Board of Pharmacy member Jack Watts, RPh, discuss pharmacy issues at the Pharmacists' Afternoon in the Legislature reception held in the lobby of the North Carolina Museum of History.

Pharmacists Afternoon in the Legislature was the most successful on record with over 100 Legislators, and 180 pharmacists and students attending. The March 13 event gave pharmacists from across the state the opportunity to meet with their elected officials to discuss issues such as Medicaid, the State Employees' Health Plan, the registration of Pharmacy Technicians, and patients' rights. The following companies helped make this possible through generous donations:

- **CVS**
- **Kerr Drug**
- **NeighborCare**
- **Medicap**
- **Neil Medical**
- **North Carolina Mutual**
- **PharMerica**
- **Winn Dixie**

Leaders Forum Brings All Stakeholders to the Table

Pharmacy professionals from across North Carolina gathered February 15-17 in Greensboro for the 20th Annual Pharmacy Leaders Forum. State Health Plan Director Jack Walker, Rep. E. Nelson Cole (D-25th District), and Theresa Shackelford of the North Carolina Department of Insurance were present to discuss issues such as Third-Party Plan Processing, Medication Systems Improvements to Promote Patient Safety, and Pharmacists Health Management Programs. Also present at the Forum were members of the North Carolina Board of Pharmacy, the insurance industry, and representatives from major chain pharmacies.

"This meeting marks the first time anyone has had all the major stakeholders involved with prescription drug benefits in the same room. The current payment system for prescription drugs is broken and we need to work together to fix it," said Dan Garrett, Executive Director of the North Carolina Association of Pharmacists.

(l to r) Larry Long, RPh, Mike James, RPh, Rep. Nelson Cole, D-25th District, and Bill Post, RPh, at the Pharmacy Leaders Forum in Greensboro.

NCAP organized the Forum, which was hosted by the North Carolina Board of Pharmacy and supported in part by Pfizer, to address three major issues important to the public: Uniform Prescription Cards, Medication Safety, and the North Carolina Asthma Pilot Project. Prescription cards have been a leading cause of confusion for patients, pharmacists and physicians because information contained on the cards is not consistent from one health plan to the next. Last July, North Carolina's Uniform Prescription Drug Identification Card statute became effective. Members of the Forum concluded that pharmacists and pharmacy technicians should move forward to report cards that do not comply with the statute to the State Department of Insurance. Due to the confusion created by the complex prescription benefits now offered by health plans, a recommendation was made that health plans develop a one-page summary of their prescription plans and share this with consumers, physicians and pharmacists.

Medication Safety was a major topic of discussion among Forum attendees. According to a report from the Institute of Medicine, 44,000 to 98,000 Americans die annually as a result of medical errors. Medication errors alone are estimated to account for over 7,000 deaths each year. It was concluded that NCAP will work with the North Carolina Institute of Medicine and the Board of Pharmacy to educate the public, develop systems improvements, and look at legislation to require continuous quality improvement programs for medical errors in the healthcare industry.

Attendees also discussed the North Carolina Association of Pharmacists' Asthma Management Pilot Project which uses pharmacists in an expanded role. The proposed project allows for the provision of asthma care services by credentialed pharmacists to children with asthma in five urban and rural North Carolina counties who are covered under the State Employees Health Plan (dependents of state employees) and the Children's Health Insurance Plan (CHIPs). The overall project is designed to improve clinical, economic and humanistic outcomes in children with asthma. Counties targeted to participate in the Asthma Management Pilot Project are Onslow, Rockingham, Guilford, Durham and Buncombe. (see related story page 22)

Third-Party Plan Processing and Pharmacist Health Management Programs were discussed in small groups to develop action items that all pharmacy stakeholders can work on together.

The number one action item for Third-Party Plan Processing was the development of a public awareness campaign administered by NCAP and funded by Pharmacy Benefits Managers. The public awareness campaign would focus on the prescription filling process and provide information to consumers on how to make the best use of their prescription benefit. By coincidence, NCAP had already scheduled a Leadership Development Conference to address this issue. The March 22 Conference focused on NCAP's 2001 Public Relations plan to increase public awareness about the value of the pharmacist and the role of the pharmacy technician. (see story page 5)

The number one action item for Pharmacist Health Management Programs was the development of a business marketing plan. NCAP's Diabetes Community Health Project Tookit already contains a business marketing plan and funds are available through a grant from the Institute for the Advancement of Community Pharmacy (IACP) for North Carolina communities to market these services. ❖

Sign Up for Tech Certification Exam Review Course

"Welcome to your review seminar. Today, what do you expect to take out of our eight hours together?"

After looking around the room for a few seconds and seeing everything from sleepy eyes to blank expressions, I offer some suggestions. "Algebra", I say. The groans begin. "Hospital calculations." The hands begin to rise along with the heads. Yes, they do know why they are here. One person says she needs help on those dosing calculations, another doesn't understand how to convert temperatures. What about pharmaceutical law and aseptic technique? Pretty soon a conversation breaks out about the metric system and another about generic names and the top 200 drugs. I am writing their requests as fast as they give them and when we are done, I look at them and say, "At the end of the day, we will cover all of this and then some. So sit back, get your calculator out and let's get started."

by Ted Spader

My partner and I have given seminars to over 20 groups throughout North and South Carolina. The technicians are as diverse as any group you could find. We have taught grandmas, college students, part-time techs and foreign med students. The one common thread that they all have is the desire to pass the National Pharmacy Technician Certification Board Exam. This exam was first given over 5 years ago and was developed as a group effort by members of ASHP, APhA and pharmaceutical associations from Michigan and Illinois. It was determined that a need existed to formalize a basic responsibility that all technicians could meet to perform their duties adequately. Since that time over 80,000 techs have become certified.

The PTCB examination is given 3 times a year at locations throughout all 50 states. The next exam in North Carolina will be given in Asheville, Durham, Charlotte and Fayetteville on July 14th with an application deadline of May 18th. In order to register for the exam, one must access the PTCB website at ptcb.org to either order a registration form or register online. A packet can also be ordered by calling 202-429-7576.

The exam consists of 125 multiple choice questions from which a score of 650 out of 900 must be achieved. The test is weighted so that hospital and retail technicians have equal opportunities. The test questions include information about pharmacy law, history, controlled substances, hospital IV administration and aseptic techniques. Much of the test focuses on math conversions, dosing problems, metric conversions, ratios, percentage preparations, allegations, hospital flow rate calculations, compounding problems and dilution of stock preps. The knowledge of commercial calculations such as net profit and business definitions along with the top 200 drugs, generic names, interactions and warnings is necessary. All in all, most people walk out of the exam wishing that they had prepared better for it.

One of the many questions I get from the audience is "If I pass the exam, then what?" The fact that a tech is at least interested in looking into the exam says that the person is motivated to excel in the field of work that they have chosen. They know how much the pharmacist depends on them and understands that a professional team is what it takes to serve the public. The personal satisfaction of passing a national board exam has got to be one of the most gratifying feelings that a technician could have. To know that you are an accepted member of a specialized group of people who have mastered a complex body of knowledge and can prove it with a license, is a great honor. You earn the respect from your patients, peers and other health care providers, not to mention the potential for improving your salary objectives has improved.

NCAP has partnered with EduTech Consulting to bring a review course to 8 locations throughout North Carolina with the intention of not only *reviewing* the basic information necessary to pass the exam but also preparing the "student" for the day of the exam. It is impossible to teach a complete pharmacy course in eight hours, and most people planning to take the test have taken some steps to prepare for it. We go over every part of the practice that the exam tests and this reassures the tech that they have the basic knowledge necessary to pass. A workbook is given to each participant. Along with lecture notes, the workbook includes problems and examples for later studying. A video on hospital pharmacy is presented with a discussion that follows. The seminar is designed to be interactive, thought provoking, casual and fun. The participant will leave tired but confident.

"Well," I say, "it's about 5:30pm and we have completed our review. Have we met your expectations?" The common answer is yes, and with a smile on their faces they leave the class. Mark and I sit for a second, sipping our last tastes of cold coffee and reflect on the day. Did everyone understand? Did we spend enough time with Judy on that allegation problem? Will they go back and study the techniques that we gave them? Was there enough time to complete everything? Will they all pass? We smile at each other, and knowing that 219 out of 220 of our "students" have passed tells us that we have done another good job. We get up, pack our materials and head to the next class. ❖

About the Author...

Ted Spader, RPh, MSPhAd, is employed with the Eckerd Corporation and can be reached via e-mail at aubsdad@aol.com

Of the 220 Technicians who have taken this course, 219 have passed the PTCB Exam.

These success stories speak highly of the presentation materials and the instructors:

- Ted Spader, RPh, MSPhAd is employed with the Eckerd Corporation. He has worked at Somerset Medical Center, is the previous owner of Ringoes Pharmacy, Inc. and was previously a District Manager with Eckerd.
- Mark Sheppard, RPh is a Corporate Trainer with the Eckerd Corporation.

You can sign up for the Technician Certification Exam Review Course by visiting www.ncpharmacists.org or call NCAP at 800.852.7343

Reidsville Free Clinic Takes Team Approach to Health Care

by Jennifer M. Bayes

The Reidsville Free Clinic is a chronic and acute care ambulatory practice that serves the working poor with no medical insurance in the Reidsville area. Patients are treated two nights a week by volunteer physicians, nurses, dentists and pharmacists. During this time we treat approximately 11 persons for medical care, four for dental care, five for clinical diabetes teaching, and fill about 25 prescriptions. Our paid staff includes an executive director, registered nurse, indigent care specialist, and clerical assistant. The clinic has a pharmacy with a limited purchased drug formulary and samples from drug companies. We have a volunteer pharmacy manager who coordinates volunteer pharmacists and regulates medication dispensing. The clinic is governed by a board of directors and Paul Mabe,MD, our volunteer medical director, who sparked the free clinic effort in 1998. The clinic also has a dentistry component that provides dental care for our patients.

In 1999, through a grant provided by the Kate B. Reynolds Charitable Trust entitled Project IDEAL (Improving Diabetes Education Access to care and Living), the clinic was able to initiate a Diabetes Care and Prevention Program. Through coordination of this program, I have three main objectives/goals. The first goal is to provide early detection and treatment of diabetes to prevent further diabetes-related complications. We have access to Annie Penn Memorial Hospital laboratory equipment in addition to the equipment provided with initial grant funds. Through objective data gathered during visits and laboratory monitoring we can follow patients for diabetes, hypertension, and lipid goal values. We also monitor the patient's renal function and keep eye exams up to date. Our second objective, with Greensboro AHEC support, is to provide education for area health care professionals on diabetes and cardiovascular complications. This helps promote a collaborative approach to patient care. Project IDEAL funding has led to a successfully completed third objective, to replicate our program in two other free clinic sites in North Carolina. The first replication site is The Open Door Clinic in Raleigh, North Carolina, where Michelle Childs, PharmD, is the coordinator. Cathey Miller, PharmD, is the coordinator at our second site, which is the Davidson County Medical Ministries in Lexington, North Carolina. Both sites have been very successful in promoting excellent diabetes care.

What unique services do you provide?

Our clinical visits are divided into three specific educational teaching opportunities. We provide each patient with a blood glucose monitor and strips. The patients leave these visits with educational materials and counseling on insulin administration, nutrition and exercise routines, proper foot and skin care, hypoglycemic and hyperglycemic education, sick day protocols, and information on diabetes complications. Patient follow-up is provided as needed. If patients need medication changes at the visits, physicians are consulted that night, and if accepted, patients can leave with their new prescriptions.

What lessons have you learned?

We have a unique practice site because we can work with a variety of physicians and other area health care professionals. This relationship has enabled us to promote a collaborative effort to provide a "team approach to health care." Working referrals have been made to area ophthalmologists, kidney specialists, and dietitians. The Rockingham County Health Department has joined our efforts to provide eye exams and special diet counseling. We also serve as a site with the health department to provide doctorate of pharmacy students the opportunity to practice diabetes care.

What were your stumbling blocks?

Due to the dynamic financial nature of our patients, we have had a turnover in the patients seen. Patients who receive Medicaid are referred out of the clinic to an area physician. Furthermore, we have had problems with the limited number of diabetes patients seen in the clinic. A health fair was held to reach area patients with no health insurance who could benefit from our program.

Where are you heading now with your practice?

With each of our three programs we must focus on sustainability. The Reidsville Free Clinic, through a collaborative relationship with the Greensboro AHEC, hopes to have two residents each year to see our diabetes patients. Through additional funding, our program will provide patients with diabetes supplies necessary for proper monitoring. Another health fair is planned this year to reach more patients in the community with hypertension, hyperlipidemia, and diabetes. Our patients' diabetes care and related cardiovascular complications have improved as shown by lab measurements, such as decreasing hemoglobin A1cs, blood pressures, lipids, and microalbuminurias. Counseling has also facilitated a healthier lifestyle. We want to continue our progress in improving our patients' diabetes and cardiovascular risk factors. Patients thrive on the opportunity to talk with someone knowledgeable about their disease. Diabetes and other patient care disease-state conditions provide our profession a worthwhile opportunity to conduct pharmaceutical patient care management and teaching.❖

About the Author...

Jennifer M. Bayes, PharmD, is employed by PharMerica as a Consultant Pharmacist. She is also Coordinator of the Diabetes Care and Prevention Program at the Reidsville Free Clinic. She can be reached via e-mail at JBayes@triad.rr.com

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Annual Winter Meeting Recap

Over 300 pharmacists and 100 pharmacy technicians attended the Annual Winter Meeting at the Greensboro Marriott Downtown, March 1-2, 2001. The meeting was co-sponsored by Campbell University School of Pharmacy, the University of North Carolina School of Pharmacy, Greensboro AHEC, and the North Carolina Association of Pharmacists.

It's not too early to register for the NCAP Annual Pharmacy Convention and Annual Carolina Seminar October 29-31, 2001 at the Sheraton Four Seasons in Greensboro. Call NCAP for details.

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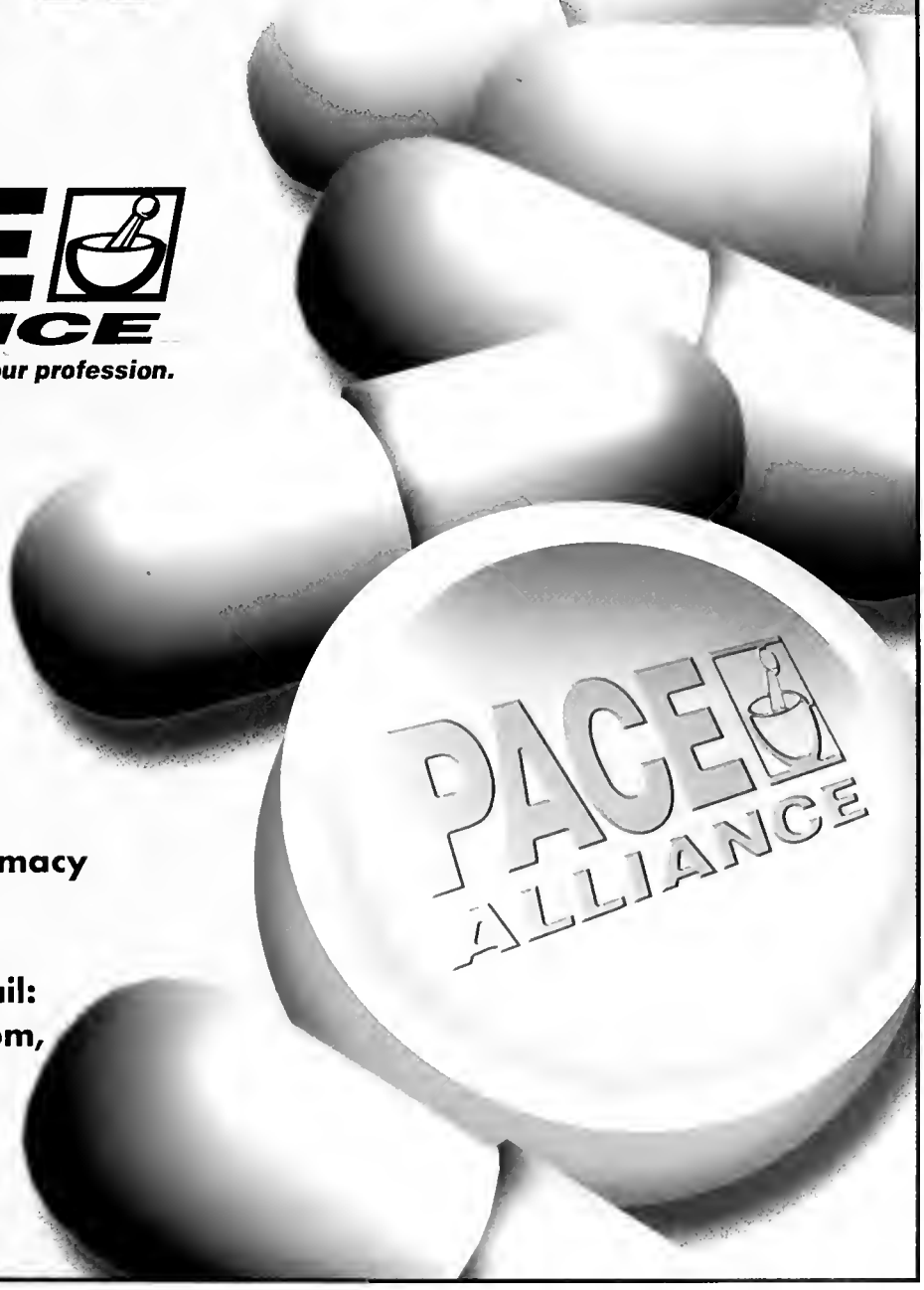

Pace Alliance has been supporting the practice of community pharmacy since 1985. To learn how you can join the only buying group owned by State Pharmacy Organizations, call Pace Alliance at 1-888-200-0998, e-mail: pace@pacealliance.com, or call Carolina Pharmacy Network at 1-800-864-3699.

Clinical Corner

Dofetilide (Tikosyn®), a New Class III Antiarrhythmic Drug

by Monty Yoder & Ellie Wright

Atrial fibrillation (AF) and atrial flutter (AFl) are two common types of arrhythmias affecting over 2 million Americans. Atrial fibrillation alone accounts for approximately 5% of hospital admissions due to cardiovascular disease. Therefore, these arrhythmias are responsible for the significant morbidity and mortality in this patient population. While the optimal treatment strategy for these arrhythmias does not exist, the primary goals of therapy are as follows: control ventricular response, restore sinus rhythm, and prevent thromboembolic sequelae[1]. Many antiarrhythmics are available that clinicians have used to manage AF and AFl with varying degrees of success. Dofetilide is the newest antiarrhythmic agent to receive FDA approval. Current product labeling states that dofetilide is indicated for the maintenance of normal sinus rhythm (delay in time to recurrence of atrial fibrillation/atrial flutter) in patients with atrial fibrillation/atrial flutter of greater than one week's duration after converting to normal sinus rhythm (NSR). In addition, dofetilide is indicated for the conversion of atrial fibrillation/atrial flutter to normal sinus rhythm[2,3]. The goal of this paper is to provide the reader with more information about dofetilide.

Dofetilide is a Vaughn Williams class III antiarrhythmic that prolongs the cardiac action potential by blocking the cardiac ion channel that carries the rapid component of the delayed rectifier potassium current.[2,3] Several clinical trials have been conducted to evaluate the efficacy of dofetilide in cardioversion and maintenance of NSR from AF and AFl. The EMERALD trial enrolled patients with AF/AFl from one week to two years duration. Approximately 50% of these patients had structural heart disease and 50% had NHYA Class I heart failure status. This trial reported a cardioversion rate of 29% in patients taking 500 _g BID. Doses of 250 _g BID and 125 _g BID resulted in cardioversion rates of 11% and 6% respectively, compared to a 1% rate in the placebo group. In the same trial, 49% of patients receiving dofetilide 500 _g BID were still in NSR after one year compared to only 16% in the placebo group. Similar patient populations were enrolled in the SAFIRE-D trial with the exception that 72% of these patients had NHYA Class II or III heart failure status. The SAFIRE-D trial reported similar findings with the probability of remaining in NSR after one year of dofetilide therapy as 0.58 in those receiving 500 _g BID. Both the EMERALD and SAFIRE-D trials demonstrated a dose dependent response in both the rate of cardioversion and maintenance of NSR.[2,3]

Dosing of dofetilide is based on a patient's QT or QTc interval as well as their calculated creatinine clearance based on the Cockcroft-Gault equation. Package labeling includes a detailed algorithm outlining a step-by-step process for determining the appropriate dose of this agent. Readers are encouraged to refer to the package insert for a more detailed explanation of dosing guidelines. Dofetilide is contraindicated in patients with a baseline QT interval or QTc >440 msec (500 msec in patients with ventricular conduction abnormalities) or patients with a calculated creatinine clearance <20 mL/min. Approximately 80% of a dofetilide dose is excreted in the urine, of which approximately 80% is excreted as unchanged dofetilide with the remaining 20% consisting of inactive or minimally active metabolites. Urinary excretion is dependent on glomerular filtration and active tubular secretion via a cation transport system. Therefore, the use of medications that can interfere with the urinary excretion of dofetilide such as trimethoprim, cimetidine, prochlorperazine, megestrol, and ketoconazole is contraindicated.[2,3]

The oral bioavailability of dofetilide approaches 96% with plasma levels reaching a peak at 2-3 hours post dose. Dofetilide's elimination half-life is approximately 10 hours and is prolonged in patients with renal impairment. Therefore dosage adjustments based on creatinine clearance are necessary. Steady state blood levels are achieved within 2-3 days[2,3].

All antiarrhythmics used for the management of AF/AFl carry the risk of proarrhythmic side effects particularly ventricular arrhythmias such as torsade de pointes. Class III agents, under which dofetilide is categorized, have a 0.1-2% incidence of torsade de pointes published in the literature. Clinical trials evaluating dofetilide therapy demonstrated that arrhythmias are the most commonly encountered side effect. Specifically, researchers reported that the frequency of torsade de pointes as an adverse event ranged from 0.3-10.5%, occurred in a dose dependent fashion, and usually presented within the first 72 hours of therapy.[1] In addition to higher doses, several risk factors exist that increase the likelihood of adverse proarrhythmic events. These factors include electrolyte abnormalities such as hypokalemia and hypomagnesemia, renal dysfunction, concomitant antiarrhythmic therapy, and drug inter-

actions. The manufacturer reports that the following medications interact with dofetilide and therefore increase systemic dofetilide exposure: Cimetidine, Verapamil, Ketoconazole, Trimethoprim alone or in combination with Sulfamethoxazole. Because dofetilide is metabolized to a small extent by the CYP3A4 isoenzyme of the P450 enzyme system, inhibitors of this isoenzyme (e.g. macrolide antibiotics, azole antifungals, protease inhibitors, serotonin uptake inhibitors, diltiazem, grapefruit juice) potentially could result in elevated plasma levels. In healthy volunteers, coadministration of dofetilide with amlodipine, digoxin, ranitidine, omeprazole, digoxin, and theophylline, or warfarin did not alter the pharmacokinetics or pharmacodynamics of dofetilide.[1,2,3]

Pfizer, Inc. manufactures dofetilide in 125 mg, 250 mg, and 500 mg capsules that are to be administered on a specific schedule every 12 hours. Because of the risk of drug-induced arrhythmias, package labeling requires that patients initiated or reinitiated on dofetilide be admitted for a minimum of 3 days to a facility that can provide continuous ECG monitoring, calculated creatinine clearance, and cardiac resuscitation. Furthermore, dofetilide is available only to prescribers who have received appropriate dofetilide dosing and treatment initiation education. Dofetilide is distributed only to those hospitals and other institutions confirmed to have received applicable dosing and treatment initiation education programs. These education programs include participating in a medical meeting led by a Tikosyn-trained speaker, review of the Tikosyn Product Monograph or the Tikosyn education video provided by the manufacturer, or completion of a web-based education program on Tikosyn. Additional information about this process may be obtained by calling 1-877-TIKOSYN (845-6796), visiting the website at www.tikosyn.com, or contacting a pharmaceutical representative from Pfizer, Inc. In the outpatient setting, dofetilide can be obtained via mail from a sole pharmacy, CVS Procare Pharmacy (1-800-238-7828), in the United States. Therefore, patients discharged on dofetilide from the inpatient setting must receive enough medication, at the patient's individualized dose, to allow for uninterrupted therapy until the patient receives the first outpatient supply.[2,3]

In summary, dofetilide is a new Class III antiarrhythmic drug indicated for the use in cardioversion and maintenance of sinus rhythm in patients with AF or AFl. Efficacy data demonstrates that dofetilide may be superior to other antiarrhythmics in the cardioversion of AF or AFl to sinus rhythm, and maintaining those patients in normal sinus rhythm for up to 1 year. Dofetilide's safety data appears to be favorable yet the risk of proarrhythmic events still exists, particularly in the patient with renal dysfunction or when doses above 500 mg are used. Pharmacists have the ability to provide pharmaceutical care by ensuring that therapy with antiarrhythmic agents is optimized. Specifically, pharmacists are in an excellent position to care for patients by monitoring renal function and electrolyte status, screening for drug interactions, recommending appropriate dosage adjustments, and providing patient education regarding dofetilide.❖

About the Authors...

Monty Yoder, PharmD, BCPS, is the Pharmaceutical Care Coordinator, Cardiology, at Wake Forest University Baptist Medical Center. He can be reached at myoder@wfubmc.edu

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1. Lenz, T and Hilleman, D. Dofetilide, a New Class III Antiarrhythmic Agent. *Pharmacotherapy* 2000;20(7):776.
2. Data on File, Pfizer Inc.
3. Tikosyn Package Insert.

ASCO-Wilmington's Strength Lies in Personalized Service

by James Strickland

ASCO-Wilmington Long Term Care Pharmacy is located in Wilmington and services long-term care facilities primarily in the central and eastern parts of North Carolina. ASCO-Wilmington has been in business for almost 40 years. We provide dispensing, IV, and consulting services. Jim Pierce, RPh, is the owner and President of ASCO-Wilmington and our staff includes six dispensing pharmacists and three consultant pharmacists.

ASCO-Wilmington's strength lies in its personalized service, which includes 24-hour on-call coverage, compounding services and consultant pharmacists on site at facilities during state surveys. As a small, independent company we have the ability and flexibility to tailor our services to the needs of each facility. In this new millennium, good service is still invaluable. Treating each facility as an individual and focusing on meeting their individual needs provides us with strong working relationships with residents, nursing staff and physicians.

One of our most appreciated services is around-the-clock on-call pharmacist coverage for all of our facilities. If there is an emergency or stat order and our E-kits do not contain the medication, then our on-call pharmacist will make sure the facility gets what is needed. Sometimes this means late night trips to the pharmacy and the facility, but we always put our residents first. We are proud that with five hurricanes, and even massive snowstorms, we have been open each day for business. Our facilities' nurses also enjoy having a pharmacist available constantly for medication-related questions – and they can come up with some good ones!

Compounding is a service that our facilities' physicians appreciate as well as our residents. One of our most popular concoctions is a liquid vitamin mix tailored to the special needs of our senior population. This mix was developed in response to a need voiced by many of our physicians. Compounding adds a whole new dimension to what we can offer our residents and is well worth the investment.

State surveys are a stressful time for facilities and we have responded by making our consultant pharmacists available to facilities during this time. This reduces stress for our nurses by letting our consultant pharmacists handle any pharmacy-related questions that may come up, and is also intended to be helpful to surveyors clearing up any perceived problems.

These three areas of service by no means include everything, but they are offered as examples of the personalized service we provide for our facilities, and as examples of what we consider necessary to succeed at our goal of providing excellent long-term care pharmacy services.

We look to the future with great excitement and great expectations. As the senior population grows, the demand for senior care pharmacists will grow. This growth will bring new challenges such as an increased workload, new reimbursement issues, and increasingly complicated medication regimen management, to name a few. We are preparing for this by stressing continuing education for our pharmacists and pharmacy technicians. With the rapid development of new medications and new technologies, continuing education is a must. All of our consultant pharmacists are Certified Geriatric Pharmacists. Certification involves having a good working knowledge of medication use specifically in the senior population. Preparation for taking the certification exam is an excellent way to review, or learn for the first time, the special concerns of medication use in seniors. We also encourage our technicians to be licensed. This provides excellent opportunities and incentives for them to further their knowledge. To meet the challenges of an ever-increasing workload we are constantly looking at ways to become more efficient in how we operate. From a consulting standpoint, laptops and consulting software are invaluable tools. These provide increased organization, the ability to analyze data in ways that without laptops and good software would not be possible, the ability to generate reports that are valuable to our facilities, and they provide more thorough and consistent medication regimen reviews. Time is also freed to perform other duties such as medication pass reviews, medication room checks and committee functions. Increase efficiency in the pharmacy is, of course, also necessary. We have found that outside consultants prove invaluable in reviewing operations periodically. They are able to look at the flow of operations from a fresh or different perspective and offer advice on how to improve. We try not to become complacent in the way we operate and constantly look for ways to improve or adapt to changes. The future offers endless opportunities for long-term or senior care pharmacy and as long as companies look ahead and plan wisely, we feel that future should be bright.

Most importantly we enjoy what we do and we hope it shows in the services we provide for our seniors. We believe if we focus on our residents and if they come first, everything else will fall into place. ❖

About the Author...

James Strickland, PharmD, CGP, is a Consultant Pharmacist at ASCO-Wilmington. He can be reached via e-mail at strickjam@aol.com

UNC Students Learn Lessons in Compassion

Much attention has been focused on the failure of pharmacists to identify potential drug interactions and to provide appropriate counseling to their patients. Studies have revealed that pharmacists in low and lower-middle income areas were nearly twice as likely to fail to warn consumers of potentially dangerous interactions. Students at the UNC School of Pharmacy, however, have several opportunities to work with homeless and indigent patients before they sit for licensure. Perhaps such exposure can ultimately help to establish more positive attitudes toward providing medical care to poor and underserved populations.

by Kristen Farris & Ashley Hoover

One opportunity available to UNC students is via the Interfaith Council (IFC) Community House in Chapel Hill. The IFC homeless shelter provides housing and meals to individuals and families in need. In addition, they also sponsor various medical clinics throughout the week to treat acutely ill pediatric, adult and psychiatric patients. This experience offers a great way for students to communicate with patients, practice pharmaceutical care, and serve their community in the process. A variety of health care professionals from the community volunteer their time to staff the clinic each week. Pharmacy volunteers participate in the adult medicine clinic held on Thursday nights due to the large amount of medication-related concerns. Each semester two pharmacy students are responsible for coordinating volunteers from the school and acquiring the donations of medications and supplies.

(l to r) UNC Hospital Pharmacy Practice Resident Brant Niedenthal, PharmD, PY3 Clinic Coordinator Kristen Farris, PY1 Clinic Volunteer Shannon Howarth, and PY3 Clinic Coordinator Ashley Hoover.

Students and faculty within the University of North Carolina School of Pharmacy enjoy the clinic immensely, making it a very popular activity. In order to volunteer, students must have completed at least one year of pharmacy school to ensure that each volunteer has an adequate base of knowledge necessary for aiding the other volunteers in proper medication management. Faculty volunteers must be licensed pharmacists and oftentimes, residents and practitioners from UNC Hospitals provide their services. One of the most appealing aspects for students and faculty alike is the opportunity to interact with patients on a one-to-one basis. Sue Eure, a PY3 student at UNC, says of her experience volunteering at the IFC clinic, "This experience allows me to apply classroom knowledge to real life. It's so rewarding to help people who would otherwise not have access to health care."

Patients at the adult clinic sign up for appointments on a first-come, first-served basis during the week prior to each clinic. A clinic coordinator organizes the patients and is responsible for pulling or creating each chart. A nurse interviews and performs the initial examination. Within the examination room a physician/physician's assistant, pharmacist, and pharmacy student sees each patient. Treatment is often difficult due to the limited amount of resources available. Most medications are donated by pharmaceutical companies upon request by the pharmacy student coordinators. If an appropriate product is not available, a prescription is written and filled under contract with Sutton's Drugstore in Chapel Hill. The most common illnesses seen in the clinic are cough/colds, upper respiratory infections, skin infections, asthma, COPD, and acute pain. Students assist by recommending the most appropriate medication from those available, and upon approval from the physician or physician's assistant, dispense the medication under the supervision of the attending pharmacist. After proper labeling, the student counsels the patient on the proper use of their medication. Despite the limited space and resources in the clinic, the opportunity to volunteer at the IFC provides a valuable learning experience in pharmaceutical care. Further, UNC students gain not only knowledge of pharmacotherapy but also lessons in human compassion. ❖

About the Authors...

Kristen Farris and Ashley Hoover are Doctor of Pharmacy Candidates and IFC Pharmacy Student Coordinators at the UNC-CH School of Pharmacy.

Residency Sharpens Geriatric Pharmacy Skills

by Shary M. Jones

As America's population ages, the use of non-prescription and prescription drugs by the elderly is rapidly increasing. With this surge, you also have senior citizens who lack the understanding of how to take their medications, when to take them, and most important, why they are taking medications in the first place. I feel that a person trained to effectively communicate with, and educate, this special population will have a strong impact by optimizing their medication regimen. Pharmacists can eliminate or decrease the common problems of non-adherence, polypharmacy, and adverse drug events associated with the geriatric population.

New Practitioner Shary M. Jones

Currently the Geriatric Specialty Resident at Alamance Regional Medical Center/Campbell University School of Pharmacy, my residency allows me to develop a wide array of skills to practice geriatric pharmacy. In my residency, I focus on comprehensive pharmaceutical care that is provided to patients over the age of 65. I practice in an ambulatory, inpatient and long-term care setting allowing for a longitudinal experience that is challenging, yet rewarding. I spend three days a week in the Pharmaceutical Care Clinic at Alamance Regional Medical Center. Area physicians refer their geriatric patients with complicated regimens that need proper education about their medicine or financial assistance in obtaining medication. A wide range of services are provided at the clinic. They may include suggesting other alternatives to the physician, disease state management, or enrolling someone in a patient assistance program because they simply can not afford their medication. The other two days a week I spend at the long-term care facility with my preceptors, Myra Mullis and Peggy McCormick, in the capacity of a consultant pharmacist. I am responsible for a group of residents for whom I perform monthly drug regimen reviews. I am also an active part of the interdisciplinary team in which I provide my input on the care of the residents. In this setting, I am exposed to patients with chronic illnesses who are bedridden and also patients who are there short term for rehabilitation. An aspect I enjoy most is my involvement in the continuity of care. I have the opportunity to see the residents come into the facility and follow their progression during their stay.

In addition to my dedicated time in the ambulatory care clinic and long-term care facility, I also give lectures to support, and community groups such as Arthritis Support, and Behavioral Medicine. Every other Thursday evening I have the opportunity to volunteer at the Open Door Clinic that serves the county's indigent population. There, I work with the area physicians performing physical assessments, obtaining histories, developing care plans, and dispensing medications.

Affiliated with Campbell University School of Pharmacy, I have an opportunity to develop a broad range of teaching skills through didactic lectures and assisting my preceptor, Michelle Fritsch, with facilitating Therapeutics case sessions and precepting pharmacy students. I particularly enjoy working with students because they keep me on my toes. I also am able to relay to them the importance of caring for geriatric patients. During the rotation, students enjoy playing the Aging Game. The game allows the students to understand the different physical changes that occur with aging. Overall, they get to perceive how it feels to age, and develop disease states and physical limitations. In accordance with the computer initiative currently implemented at Campbell, my residency project was to design and implement a web-based therapeutics geriatric case to study the impact on student learning. Students utilized the case through interactive multimedia programming, which had layers of detail available for each decision point. Various help buttons were available for direction to different tutorials. Outcomes measured included a pre-test, post-test and student evaluation. Comparison of the test results yielded a five percent (5%) increase in examination scores with favorable acceptance from student evaluation results. My results will be presented at the Southeastern Residency Conference.

The skills that I have developed at this point in my residency are exactly why I pursued post-graduate training. My goals were to enhance skills in providing direct patient care, investigate ways to optimize patient care, explore academia, communicate effectively with other health-care professionals, and become more aware of the pharmacist role in the long-term care setting. Nearing completion of this residency, I feel I have advanced beyond the basic knowledge foundation I had at graduation. I can now practice in a broad range of settings based upon the knowledge that I have gained, which is why I would encourage anyone to complete a residency. My year has truly been an enlightening experience! ❖

About the Author...

Shary M. Jones, PharmD, RPh, is a Geriatric Specialty Resident/Clinical Instructor, ARMC/Campbell University College of Pharmacy. She can be reached at janeshar@armc.com

Call for Election and Award Nominations

ELECTIONS

Deadline for Nominations is June 29, 2001.

NCAP:

During the summer NCAP will elect a 2002 President-Elect (to serve as President in 2003) and two At-large Board members (3-year terms). Members may submit nominations or requests to be considered for these positions. Send to NCAP Nominations Committee, 109 Church Street, Chapel Hill, NC 27516 (FAX 919-968-9430 or email to linda@ncpharmacists.org)

Acute Care Practice Forum:

The Practice Forum will elect a Chair-Elect (3-year term), three Executive Committee members (3-year terms) and one Delegate to ASHP (3-year term). Members of the Practice Forum may submit their nominations to Vance Collins, Chair of the Nominations Committee (FAX 252-535-8273 or email to vcollins@halifaxrmc.org).

Ambulatory Care Practice Forum:

The Practice Forum will elect a Chair-Elect (3-year term). Members of the Practice Forum may submit their nominations to Linda Goswick at NCAP (FAX 919-968-9430 or email to linda@ncpharmacists.org).

Chronic Care Practice Forum:

Call for Nominations to be announced at a later date.

Technician Practice Forum:

The Practice Forum will elect a Chair-Elect (3-year term). Members of the Practice Forum may submit their nominations to Dot Cowan, Chair of the Nominations Committee (FAX 910-577-2502 or email to jamin4jesus@ec.rr.com).

AWARDS

Deadline for Nominations is June 29, 2001.

It is a privilege for the North Carolina Association of Pharmacists to recognize excellence within the profession. NCAP will hold its Awards Ceremony during the Convention October 29-31 in Greensboro, NC. The Board of Directors invites NCAP members to make nominations for the following awards. **Nominations must include biographical data on the nominee for review by the Awards Committee. Submit to Awards Committee, NCAP, 109 Church Street, Chapel Hill, NC 27516 (Telephone 800-852-7343; FAX 919-968-9430 or email linda@ncpharmacists.org).**

Don Blanton Award:

Presented to the pharmacist who has contributed most to the advancement of pharmacy in North Carolina during the past year. This award was established by Charles Blanton in memory of his father, Don Blanton, who served the North Carolina Pharmaceutical Association as President 1957-58.

DuPont Innovative Pharmacy Practice Award:

Presented to a pharmacist practicing in North Carolina who has demonstrated

Innovative Pharmacy Practice resulting in improved patient care.

Pharmacists Mutual Distinguished Young Pharmacist Award:
Criteria for this award are: (1) Entry degree in pharmacy received less than 10 years ago (1991 or later graduation date); (2) Licensed to practice pharmacy in NC; (3) Actively practices retail, institutional, managed care or consulting pharmacy; (4) Participates in national pharmacy associations, professional programs, state association activities and/or community service.

Wyeth-Ayerst Bowl of Hygeia Award:
Criteria for this award are: (1) Licensed to practice pharmacy in NC; (2) Has not previously received the Award; (3) Is not currently serving nor has he/she served within the immediate past two years on its awards committee or as an officer of the Association in other than an ex officio capacity; (4) Has compiled an outstanding record of community service, which, apart from his/her specific identification as a pharmacist, reflects well on the profession.

Pharmacist/Technician of the Year:
Each Practice Forum will honor a Pharmacist/Technician of the Year. Criteria are: (1) Service to the profession, (2) Contributions to pharmacy programs; (3) Cooperation with the entire health care team and (4) Service to the community. Members of the Practice Forum may submit nominations for these awards. **Nominations must include biographical data on the nominee.**

Acute Care: Submit nominations to Vance Collins (FAX 252-535-8273 or email to vcollins@halifaxrmc.org).

Ambulatory Care: Submit nominations to Linda Goswick at NCAP (FAX 919-968-9430 or email to linda@ncpharmacists.org).

Chronic Care: Call for Nominations to be announced at a later date.

Technician: Submit nominations to Dot Cowan (FAX to 910-577-2502 or email to jamin4jesus@ec.rr.com).

CONTINUING EXCELLENCE PROGRAM

Deadline for applications is August 1, 2001.

The purpose of the Continuing Excellence Program is to recognize individuals who have distinguished themselves through sustained service to the profession and the public and to promote an awareness of NCAP and the profession of Pharmacy among the public and other health professions. Program Criteria and application form are available on the NCAP website (www.ncpharmacists.org) or you may contact Linda Goswick at NCAP (Tel. 800-852-7343; FAX 919-968-9430 email linda@ncpharmacists.org). Award recipients will be recognized at the October Convention in Greensboro.

Asthma Pilot Project Offers Chance to Expand Care

The Asthma Pilot Project is providing NCAP with a chance to replicate concepts from the Asheville Project on a statewide basis. If we can expand asthma care statewide, other disease states such as diabetes and hypertension will follow. If you have completed the Asthma Certificate Training Program and practice in Buncombe, Guilford, Durham, Rockingham, or Onslow counties please let us know.

Program Purpose:

Implement an asthma health management program for pediatric patients covered under the State Employees Health Plan (SEHP) and CHIPS in five North Carolina counties (Buncombe, Guilford, Durham, Rockingham, Onslow) and demonstrate effectiveness by documenting clinical, humanistic and economic outcomes.

Program Design:

A collaborative effort based on the "Asheville Project." The program will identify asthma patients through office, hospital, ER claims, and pharmacy claims history. The patients will be enrolled to participate in the program and certified pharmacists will provide asthma education and follow-up. The patient's physician will receive regular updates on the patient's progress and issues.

Program Administration and Leadership:

Dr. Genie Komives will serve as the program leader. Paul Sebo of the SEHP and Dan Garrett of the North Carolina Association of Pharmacists will provide staff support for program administration.

Expected Outcomes:

- Economic: reduction in hospitalizations and ER visits, and an increase in use of inhaled steroids and preventative medications.
- Clinical outcomes: improved FEV, decreased asthma symptoms at night
- Humanistic: decreased number of days asthma-limited activity.

Results of claims data will also be compared with plan participants in counties not in the pilot. Dr. Komives will work with Dale Christensen of the UNC School of Pharmacy to establish and monitor outcome parameters.

Provider Fees and Payment:

Jane Frankenfield of AdvancePCS will negotiate with the Piedmont Pharmaceutical Care Network (PPCN) to establish a capitated fee for services. PPCN will be responsible for establishing, credentialing, and paying the provider network.

Target start date:

June 1, 2001, pending identification and enrollment of patients with PPCN providers. BCBS and AdvancePCS are responsible for patient identification and, the SEHP will work with PPCN to enroll patients.

Program Support and Consistency:

- Roy Pleasants of Campbell University School of Pharmacy will develop a "tool kit" (with support from GSK) and training seminar for providers to insure consistent providers services and documentation.
- Dr. Spencer Atwater, Chairman of State Asthma Board, will identify local physician advisors for each county.
- Rachel Piche of the State School Nurse Association will identify school nurses in each county to support the program and help enroll patients.
- Lori Colemon will coordinate with local pharmacist provider champions in each county in concert with the physician advisors and school nurses.
- Roy Pleasants, Paul Sebo, Jane Frankenfield, Dr. Atwater, Lori Colemon and Dr. Komives will serve together as a communications committee.

SEHP/CHIPS Asthma Pilot Leadership Team Chairpersons

Oversight
Dr. Genie Komives, 919-765-2505,
engenie.komives@bcbsnc.com
Toolkit
Roy Pleasants, Campbell Univ., 919-684-6369,
pleas005@mc.duke.edu
Community Champions
(Dr. Atwater to identify Physician Advisors)
Lori Colemon, 800-494-3053 x497, lcolemon@hotmail.com
Outcomes
Dale Christensen, UNC, 919-966-1271,
dale_christensen@unc.edu
Education/Training Symposia
Steve Caiola, UNC, 919-966-4557,
steve_caiola@unc.edu

A complete list of SEHP/CHIPS Asthma Pilot Leadership Team members and leaders can be found on the NCAP website at www.ncpharmacists.org ❖

Continuing Education

In order to better serve our members NCAP will mail a special CE Supplement only to members who request it. CE is no longer published in the *North Carolina Pharmacist*, leaving more room for news of interest to all readers. As always, Continuing Education is available only to members. Members who would like to be added to the mailing list for CE should contact Teressa Reavis at teressa@ncpharmacists.org or call (800) 852-7343 ext. 27.

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Auxiliary Awards Scholarships

The NCAP Auxiliary Scholarship Award was recently presented to Campbell University School of Pharmacy student Amanda Lee Bryan. At the University of North Carolina School of Pharmacy, Lori Altman and Leigh Roberson received The Vivian Smith Scholarship, and Elaine Chin received the Lucille Rogers Scholarship.

The next Auxiliary Board meeting will be held at 10:00 am on June 12 at the Institute of Pharmacy. The Auxiliary is planning some exciting events for everyone who attends the Annual Pharmacy Convention October 29-31 at the Sheraton Four Seasons in Greensboro. Make your plans now.

Missing: One Kangaroo

The NCAP Auxiliary would like to resurrect Katy's Kids, an educational program designed to teach young children about appropriate and responsible medication use, but they need to locate a missing kangaroo costume that was used in their presentations. The original Katy's Kids program was presented to elementary school children from 1992-97. The kangaroo costume has not been seen since that time and the Auxiliary needs help locating it. If you, or anyone you know has any information about the "kangaroo" please contact the NCAP office.

Michalets Recognized

In order to access the impact of the articles it publishes, *Pharmacotherapy* performed a comprehensive analysis examining the frequency with which research and review articles they published in 1997 and 1998 were cited in other bioscience journals. A recent ACCP Report spotlighted and congratualted Elizabeth Michalets, PharmD, BCPS, as being the most-cited author during that time. Michalets is the Pharmacy Education Coordinator at Mission St. Joseph's Hospital in Asheville, NC.

Local Association Contacts

The following is a list of contact information for local pharmacy associations in North Carolina:

Alamance Pharmaceutical Society
Jack G. Watts, jack@netpath.com
336-226-5861

Blue Ridge Pharmaceutical Association
Steve Critz, critzsteve@aol.com
336-651-8579

Cabarrus County Pharmaceutical Association
Whit Moose, Jr., moosedrug1@ctc.net
704-436-9613

Cape Fear Pharmaceutical Society
Barbara Swartout, pilldr@kdcc.net
910-424-3100

Catawba Valley Society of Pharmacists
Mike Long, 828-322-7717

Cleveland County Pharmaceutical Association
Fern Douglass Potts, 704-487-3157

Columbus Bladen Pharmacy Assoc.
John Watson, jwatsonrph@intrstar.net
910-642-0388

Crystal Coast Pharmaceutical Assoc.
Phillip Alexander, Jr., 252-247-2174

Davidson County Pharmaceutical Association
Robert Guy, the5guys@northstate.net
336-476-5632

Durham-Orange Pharmacist Assoc.
Jennifer Burch, jburch@aol.com
919-220-5121

Foothills Pharmacy Association
Gill Ripley, gillripley@aol.com
336-835-4100

Four-County Pharmaceutical Assoc.
Steve Dittert, dittert@gloryroad.net
919-575-3900 Ext. 5658

Gaston County Pharmaceutical Assoc.
John Anderson, andersoj@gmh.org
704-864-9163

Guilford Co. Society of Pharmacists
Frank Burton, burtonrx@juno.com
336-272-7139

Harnett County Pharmaceutical Assoc.
Herman Medlin, 919-894-5764

Haywood County Pharmaceutical Association
Kermit Wells, 28-648-2321

High Country Pharmacy Association
Margaret Steward, 828-262-4137

Johnston County Pharmaceutical Association
Ben Pell, 919-934-8171

Mecklenburg County Pharmaceutical Association
Amy Feltz, toddamyfeltz@att.net
704-332-4131

Moore County Pharmaceutical Assoc.
Susan Stroder, 910-944-2351

New Hanover County Pharmaceutical Association
Davie Waggett, dwagg169@aol.com
910-762-6278

Northeastern Carolina Pharmaceutical Association
Huyla Coker, huyla_coker@med.unc.edu
252-534-1661

Northwest Pharmacists Association
Mike Brewer, debmike78@aol.com
336-718-1416

Onslow Pharmaceutical Association
Kenneth Johnson, drkenbo@ncnets.net
910-455-9222

Person County Society of Pharmacists
Kim Frazier, 336-597-5031

Randolph Pharmaceutical Association
Charles Owen, 336-629-3302

Rockingham Pharmaceutical Association
Keith Layne, 336-627-4600

Southeastern Pharmaceutical Association
James Carroll, 910-671-5174

Union County Pharmaceutical Assoc.
Frank Catoe, fcatoe@carolinas.org
704-283-3192

Wake County Pharmaceutical Assoc.
Ron Logan, 919-468-0424

Wayne County Pharmaceutical Society
Paul Chu, chupcam@aol.com
919-759-2370

Western Carolina Pharmaceutical Association
Tre Reinhardt, 28-299-2511

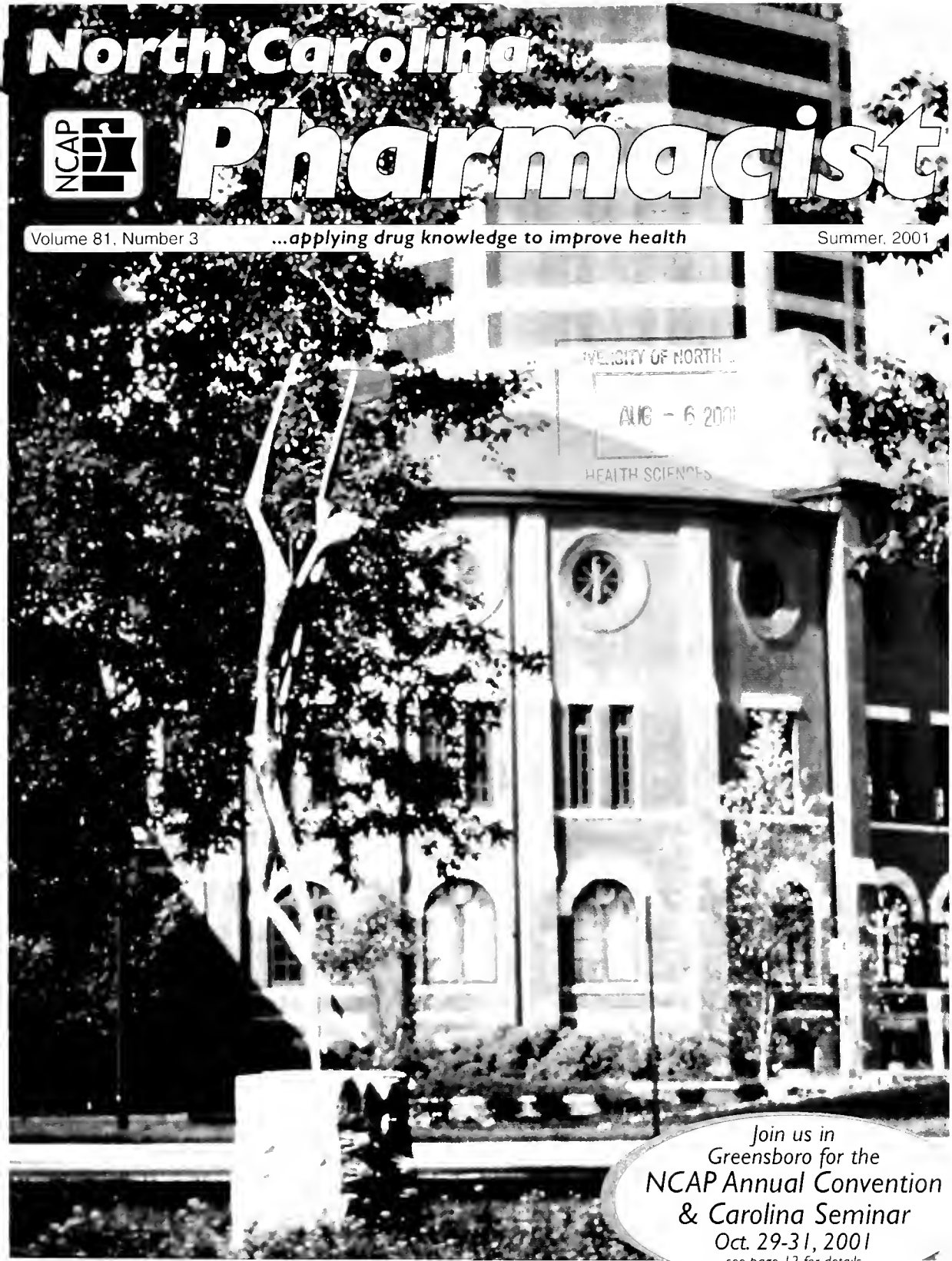
Wilson County Pharmaceutical Assoc.
Bill Williams, bwilliams@coastalnet.com
252-399-2109

2001 Calendar

June 3-6: ***ASHP's Annual Meeting 2001***, Los Angeles Convention Center. Visit www.ashp.org or call 301.657.4383 for more information.

October 29-31: ***NCAP Annual Pharmacy Convention and Annual Carolina Seminar*** Sheraton Four Seasons, Greensboro. Topics include Pharmaceutical Approaches to Infectious Disease Therapy, Medication Errors, Prevention and Detection.

Please visit the NCAP website at www.ncpharmacists.org for more information on upcoming meetings and events.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Summer, 2001
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North Carolina Pharmacist

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About the Cover: Downtown Greensboro's Old and New Architecture. Photo courtesy of the Greensboro Area Convention & Visitors Bureau.

Inside

Voice & Vision

Daniel G. Garrett
Executive Director

Employee Pharmacists Must Realize the Benefits of a Strong, Unified, Professional Organization

"If you have built castles in the air, your work need not be lost. That is where they should be. Now put the foundations under them."

- Henry David Thoreau

This is my last commentary as the Executive Director of the North Carolina Association of Pharmacists. I will begin a new role working for the Foundation of the American Pharmaceutical Association in July 2001. It has been a privilege and an honor to serve pharmacists in North Carolina for the last three years.

I used the quote above by Thoreau as the basis for my initial Voice and Vision and I have referred to this theme, and the points I raised initially, to guide me along the way. It is amazing to me how much NCAP and its members have accomplished in such a short period of time:

- In 1998 we were talking about unifying our professional organizations and we did that to start the new millennium.
- We combined the *Carolina Journal of Pharmacy* and the *NCSHP Newsletter* to become the *North Carolina Pharmacist* and established our presence on the internet at www.ncpharmacists.org.
- The initial outcomes of the Asheville Project for 49 patients with diabetes were published in 1998 and we now have data on over 400 patients for diabetes, asthma, hypertension and lipid management.
- In June of 1998 there was an idea to develop a tool-kit for replicating the Asheville Project and we now have distributed the Diabetes Community Health Project Tool Kit on CD ROM to over 120 pharmacists in 35 states and 11 foreign countries.
- We have had eight successful statewide meetings in the last three years and the plans for our October 29-31 convention in Greensboro include our first ever House of Delegates.
- Pharmacists across our state are volunteering and supporting free clinics for the indigent in over 30 communities.
- The Piedmont Pharmaceutical Care Network has been formed to establish a network for pharmacist reimbursement for disease state management.
- The State Employees Health Plan and CHIP program are working with NCAP to initiate a pilot project for pediatric asthma management by pharmacists in 10 counties.

What is striking to me about this list of accomplishments is that all of these were commented on as possibilities in my initial Voice & Vision. I believe that you can only achieve the future you see.

The leaders of NCAP have positioned the profession to shape a new reality for pharmacy. The future for pharmacists in North Carolina is only limited by their individual dreams for our profession. We now have the Clinical Pharmacist Practitioner Act and Regulations, we have passed the Universal Prescription Card Act, and we will pass the Pharmacy Technician Bill this summer. The impact of expanded roles for pharmacists and technicians, coupled with streamlined processes for prescription filling, will not be fully realized for a decade. My prediction is that in ten years we will see dramatic changes in pharmacy that will enable pharmacists to do what they do best, help patients.

Many people have asked me what has been the greatest effect of unifying the pharmacy organizations. It is hard to come up with one answer. We have benefited by combining resources to support an outstanding staff, renovated the Institute of Pharmacy, implemented a new computer system, developed the local association speakers' bureau, solidified relationships with national organizations, enhanced our continuing education offerings, shared leadership, increased understanding of the needs of diverse pharmacy practice settings, and increased our lobbying efforts. I think the biggest impact though is on how the rest of the world views pharmacy. Prior to unification other stakeholders in healthcare and public interests in North Carolina had a clouded view about who represented pharmacy. Now that view is clear. It is NCAP.

This brings me to the greatest challenge that NCAP must face, getting employee pharmacists to realize the benefit of a strong and unified professional organization. It is a paradox to me that pharmacists are getting paid more than ever before for dispensing drugs and are less satisfied with their jobs than ever. The resolution to this predicament I think lies in the transformation of our profession. We must see the future of pharmacists as patient care providers and continue on the path that NCAP has set to achieve this new reality.

A core group of pharmacy leaders in our state have dedicated their careers and professional passion to the mission of NCAP, "to unite, serve and advance the profession for the benefit of society." To these people I owe a great deal of gratitude and I say "thank you!" To many pharmacists who do not realize the impact that NCAP is having I say "step up!"

We have built our castles in the air and have put foundations under them. It is now time for all pharmacists to help NCAP achieve the future we see.

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
phone (919) 967-2237 • fax: (919) 968-9430

William L. Harris, Jr.
President, NCAP

Dear NCAP member,

Join us in Greensboro! Mark your calendar and plan to attend the NCAP Annual Convention and Carolina Fall Seminar October 29-31 in Greensboro. The NCAP House of Delegates, NCAP awards presentation, reception, and leadership dinner with Past Presidents are scheduled for October 29. A wide variety of continuing education topics will be presented on October 30 and 31, including sessions on infectious disease, detecting and preventing medication errors, medication adherence, ethical issues in healthcare and numerous workshops on pharmaceutical care issues. I hope you will plan to attend one or more days. NCAP needs your participation and support.

Fred Eckel needs your support now that he has assumed the role of NCAP Executive Director. Fred has previous experience in this position and is very enthusiastic to continue the many NCAP projects and goals. The Board wishes Dan well in his new job with APhA and thanked him at the June board meeting for his dedication and accomplishments as Executive Director for NCAP over the last three years.

Support Senate Bill 974. Are pharmacists healthcare providers? We should not hesitate to answer yes, absolutely. Unfortunately, pharmacists are not currently recognized under the Social Security Act as healthcare providers. Other healthcare practitioners, including physician assistants, nurse practitioners, certified nurse midwives, clinical social workers, registered dietitians and psychologists, are recognized and can bill Medicare for their patient care services.

Pharmacy leaders are taking action in Congress and at the state level to change this enigma, a condition that has existed since passage of the Medicare Act in 1965. Currently, pharmacists are eligible only to charge Medicare for patient care services provided as incident to a physician's service, at the lowest billing code, which is equivalent to approximately 10 minutes of provider time spent with the patient. Changing this situation is critical to the advancement of the profession of pharmacy.

Senator Tim Johnson, South Dakota, recently introduced legislation to change the Medicare Act to recognize pharmacists as healthcare providers within the Medicare program. But, the pharmacy profession needs your help in getting this legislation passed. Please write a letter, send an e-mail message (via www.congress.org) or make a telephone call to Senator Jesse Helms, Senator John Edwards, and your U.S. Representative in Congress to ask them to vote for this legislation. Ask the Senators to co-sponsor Senate Bill 974, the "Senate Bill Medicare Pharmacist Services Coverage Act," which has already been introduced. Ask your Representative to support this legislation when it reaches the U.S. House. Apparently, a personal letter mailed to congressional members is the most effective method.

You may give your own reasons why the Senators and Representatives should support this legislation, or you may include some of the following: (1) pharmacists' services in patient care are underutilized, (2) other practitioners are asked to assume responsibility for drug therapy management solely because the other professionals are recognized providers and able to generate revenue, (3) pharmacists' specialized training in drug therapy management has been demonstrated in numerous studies to improve the quality of patient care and (4) utilizing pharmacists on health care teams reduces the costs of complications associated with medication use.

Proposed Rx Discount Card. A second issue that needs your attention is the recently proposed prescription discount card. Pharmacists need to notify their Senators and Representatives in Congress that this is not a good alternative to prescription drug coverage under Medicare with included pharmacy benefit. Please let your Senator or Representative know that pharmacists must be included in the drug coverage to ensure that patients receive medication therapy management, medication counseling, and monitoring for adverse medication effects and drug interactions with other drugs, herbals, alternative substances and foods.

While the pharmacy profession has made progress this year educating congressional members and the public about the role of pharmacists in healthcare, we must continue our efforts to communicate the value of pharmacists to our patients. The best method to ensure success in the legislative process is to motivate our patients to write or call their Senators and Representatives in North Carolina and Washington to request support for pharmacist professional services in all healthcare legislation and Medicare programs.

Sincerely,
William L. Harris, Jr., RPh, President

...applying drug knowledge to improve health

Adapting the Asheville Project

by Sylvia Saint-Amand

Robeson County, North Carolina is located in the southeastern corner of the state, bordering South Carolina. Despite a scenic location on the Lumber River and close proximity to beaches, lakes and tourist destinations, Robeson County ranks as one of the poorest counties in North Carolina. The county has lost nearly 7,000 jobs in the past five years, has an unemployment rate more than double the state average, and a per capita income of only $14,644/year (91st of the 100 counties.) As with most poor areas, the health of residents suffers due to lack of income and resources. The mortality rate is 25% higher than the state average for cerebrovascular disease, 42.6% higher for acute myocardial infarction, and more than 50% higher for diabetes. Of the state's 100 counties, Robeson County ranks first in diabetes-related mortality, second in diabetes-related amputations, and third in diabetes-related cardiovascular disease.

All of the above figures serve as background to explain why the Asheville Project generated so much enthusiasm in this community. The Asheville Project represented an excellent opportunity to provide valuable healthcare education to an underserved area while simultaneously showcasing the talents and skills of area pharmacists. Robeson County seemed a perfect site to duplicate the Asheville Project formula and within a short time frame local pharmacists had been recruited to participate and Southeastern Regional Medical Center (SRMC), the second largest county employer, agreed to act as a corporate sponsor, waiving insurance co-pays on diabetes medications and meter strips for participating employees.

The initial response from the hospital and pharmacists certainly seemed positive, but the program quickly began to encounter problems when pharmacists were required to complete a diabetes certificate program prior to enrolling patients. Enthusiastic pharmacists began to reconsider participation due to time constraints, leaving only a willing corporate sponsor, SRMC, but no healthcare providers. Our challenge then became to develop a diabetes program that relied on hospital-based pharmacy staff rather than community-based pharmacists yet still emphasized the role of pharmacists in healthcare.

Problems and Adaptations

The SRMC program envisioned would be similar to the Asheville Project. Employees with diabetes covered by the hospital's insurance program would meet monthly with a pharmacist to review diabetes topics, self-monitoring results, and laboratory test results. Pharmacists would help participants set management goals and help patients track their progress towards those goals. Participants would be required to attend three group classes on diabetes management in addition to their monthly appointments. In exchange, employees would have co-pays waived on all oral diabetes medications, insulin and glucose meter test strips, plus they would receive Hemoglobin A1c tests every six months and lipid panels yearly at no cost from the hospital laboratory. In implementing this "Asheville-like" project we encountered a number of problems that required changes from the original Asheville Project concept. A few of these problems and their solutions are described below.

Problem #1 – How to inform employees of the new program. The Asheville Project had a large "kick-off" meeting to provide information to city employees with diabetes. In Asheville, patients were divided among participating pharmacists for appointments. Each pharmacist counseled only a limited number of enrollees. SRMC had only one full-time primary care pharmacist with help from two pharmacy practice residents. We worried that a large "kick-off," enrolling many people at once, would be too much of a burden for the small staff (all of whom had other responsibilities).

Solution – Rather than go to the patients, we had the patients come to us. A "teaser" type of flyer with a number to call for more information was sent to all employees in their paychecks. Employees then had to take the initiative to call for details, decide if the program would benefit them, and schedule an enrollment appointment. Appointments were scheduled around pharmacists' required duties. After the initial rush of appointments had slowed, a follow-up article was published in the hospital newsletter as a reminder to employees who may have forgotten to call. We plan to continue promoting the program periodically, but so far, word-of-mouth has been the best advertisement.

Problem #2 – Duplication of Services. One of the biggest problems faced by the Employee Diabetes Project was overcoming the fear from our Diabetes Community Center that we would be taking their patients and duplicating their services. The Diabetes Community Center is an outpatient diabetes education center supported by the hospital. The facility opened in 1999 and has worked extremely hard to gain acceptance from the medical community. The staff of the Diabetes Community Center wanted to be sure that education received at both sites was consistent and followed American Diabetes Association guidelines. Additionally, staff feared that not only would we see SRMC employees, but that we would continue to expand the program to non-employees.

Solution – Although the Diabetes Community Center objected to the program initially, their main concern seemed to be that patients be given up-to-date, accurate information. To alleviate fears in this area, joint meetings were held between the pharmacists and DCC staff to discuss program content and specifically, ways to co-ordinate the two separate programs. As the two teams met, the DCC staff came to realize that the pharmacists were well versed in diabetes management and had the same goals as the DCC – to help patients better manage their disease.

Once the two groups were working together, the first issue addressed was how to eliminate duplicate services. The DCC sponsored several group classes each month, so rather than develop new classes, SRMC employees were referred to the DCC for group education. Pharmacists volunteered to teach a portion of these classes in order to alleviate the burden on DCC staff members.

A stickier problem, however, was the fear that pharmacists would be taking patients away from the DCC. In order to compromise on this issue, it was decided that patients enrolled in the employee diabetes project would automatically be enrolled in the DCC. The DCC typically schedules quarterly appointments, while the employee project called for monthly pharmacist visits.

To avoid inconveniencing patients, the pharmacist visits are skipped in months that a DCC visit is scheduled, so that most patients see a pharmacist eight times per year rather than 12.

After a patient has a DCC visit, data is sent to the employee program showing self-monitoring results, topics discussed, and goals for future visits. The information and goals provided help the pharmacist decide which educational areas to emphasize with the patient. The cross flow of information has been difficult to coordinate, but willingness to work together between the two groups has led to a needed program that otherwise may not have been implemented.

Problem #3 – Medical Consent. The Asheville Project had one medical director who wrote an introductory letter to the medical community explaining the program and how it could benefit both patients and the medical community. In addition, the medical director could authorize laboratory testing. In our small town, competition for patients is intense. Having a medical director seemed threatening to some providers, so we opted not to have a medical director. This decision, however, left us with the problem of how to introduce the program to local healthcare providers and how to get orders for needed laboratory testing.

Solution – Introduction of the program was fairly simple. A letter was sent to each area medical provider. The letter was adapted from the Asheville Project's introductory letter, but was signed by SRMC's pharmacy director and the DCC's director rather than by a physician. Although we did not have the benefit of a physician actively promoting the project, we met with little resistance from the medical providers. Out of 153 letters sent, only one provider called with concerns.

To receive laboratory orders, a consent form was developed and sent to individual physicians. When an employee expressed an interest in the program, the physician was faxed a consent form which allowed their patient to participate in the program and it served as an order form for all needed laboratory tests. Physicians were requested to return signed consent forms to the pharmacy via fax. Frequently, however, consent forms were not returned, causing delays in patients enrolling. In these cases, patients were asked to hand carry the form to their next doctor's appointment and ask for a signature. Patients seemed willing to perform this task and to date, no medical provider has refused to allow their patient to participate.

Problem # 4 – Time. Far and away, the largest problem faced in implementing this "Asheville-like Project" has been time constraints. The pharmacy staff is limited and there is no clerical or secretarial staff. For each patient enrolled, a pharmacist must copy all data, sending it to both the DCC for their records and to NCCPC for statistical support. Medical consent must be obtained. The hospital's pharmacy benefit manager must be notified of the patient's inclusion so that medication co-pays will be waived. Laboratory visits must be coordinated and appointments must be scheduled and often rescheduled when visits are missed. Individually, none of these activities is time-consuming, but grouped together and multiplied by the number of diabetes patients, the time commitment can seem overwhelming.

Solution – Unfortunately, there is no true solution to this problem. So far, the staff has been very dedicated to the program and willing to spend extra time on it, but a long-term solution is necessary. We hope to expand staffing by involving more of the hospital's pharmacy staff in counseling. Currently, four additional staff members have completed diabetes certificate programs and have expressed an interest in becoming involved. Two new employees at SRMC's pharmacy have ambulatory experience and are committed to working a few hours per week in the Employee Diabetes Program.

Results

Twenty-four patients have enrolled in the program since November 2000 with new patients being added at an average of two per month. Twenty-two participants are hospital employees, while two are spouses/dependents of employees. At this stage of the program, only a handful of enrolled employees have completed follow-up hemoglobin A1cs, so objective data on the program's success is lacking. What is not lacking though is appreciation from employees.

The majority of enrollees have been extremely supportive of the program. They feel they have a support group within the hospital and frequently seek out their pharmacist to ask questions or just report small victories. Even patients who have received prior diabetes education have stated they feel they have a "cheerleader close by" who can encourage and motivate.

Despite the problems encountered and the changes that were made to adapt the Asheville Project to our site, participants and pharmacists both feel the program is worthwhile. Our hope is to make all employees and their dependents aware of the program and excited about the opportunity to learn more about diabetes.

About the Author...

Sylvia Saint-Amand, PharmD, MBA, is an Ambulatory Care Pharmacist at Southeastern Regional Medical Center. She can be reached via e-mail at sainta01@srmc.org

In Memoriam: Alfred H. Mebane III

Alfred H. Mebane III, Executive Director of the North Carolina Pharmaceutical Association (currently known as the North Carolina Association of Pharmacists) from 1977 to 1998, died Thursday, April 26 in Chapel Hill.

"For nineteen years Al served the association faithfully and was recognized as a leader in pharmacy not only in North Carolina, but nationally as well. He certainly left a significant mark on the profession of pharmacy," said Dan Garrett, Executive Director of the North Carolina Association of Pharmacists.

He was born October 15, 1932 in Concord, NC and was a 1955 Graduate of the University of North Carolina-Chapel Hill School of Pharmacy.

From 1956 to 1971 he managed Franklin Drug Store in Greensboro, NC. In 1972 he became Owner and Manager of Elm Street Pharmacy in Greensboro where he worked until 1977. He came to Chapel Hill that year to begin his career at the Institute of Pharmacy as Executive Director of the North Carolina Pharmaceutical Association.

He was past president of the North Carolina Academy of Practical Instructors in Pharmacy, the Greensboro Society of Pharmacists, and served as president of the National Council of State Pharmaceutical Association Executives in 1991-92. He was also a past Board Member of the North Carolina Institute of Medicine and active in the North Carolina Society of Hospital Pharmacists and the American Society for Pharmacy Law.

Other memberships included the American Pharmaceutical Association, the National Association of Retail Druggists, and the APhA Academy of General Practice. Additionally, he was a Visiting Clinical Instructor of Pharmacy at the University of North Carolina-Chapel Hill.

In 1991 he received the School of Pharmacy Distinguished Service Award from the University of North Carolina-Chapel Hill.

Alfred H. Mebane III, 1932 - 2001

He was a member of the Chapel Hill Human Services Advisory Board from 1988 to 1990, he served as a Paul Harris Fellow in the East Chapel Hill Rotary Club, and he was a member of University Presbyterian Church.

Survivors include his wife, Elizabeth "Betsy" Dunn Mebane of Chapel Hill, sons Alfred H. Mebane IV, Alexander Dunn Mebane, and daughter Ann Mebane Clampett.

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Clinical Program Direction at Holladay Healthcare

by Margaret Sgritta

I became director of Clinical Program Development at Holladay Healthcare, Winston-Salem, NC in July 2000. I perform this function in addition to my role as a consultant pharmacist, a position I have held with Holladay, Kindredcare, Neil Medical and CVS pharmacy.

During my 15 years in long-term care consulting I have developed numerous programs for older adults, caregivers, pharmaceutical and medical professionals, education facilities and even broadcasting.

Since assuming my current position, I have provided programs to educate employees of Holladay, its client senior care facilities, and the patients themselves. My goal is to improve quality of life through the education of caregivers and individuals. These education programs make Holladay's employees better consultants and help clients provide better patient care and deal with regulations, all at a minimal cost.

At Holladay, I have developed "Immunization for Staff of LTC Facilities," a program for long-term care providers. The goal of this program is to reduce employee transmission of flu and pneumonia, which can be deadly to patients.

"Adult Immunizations," a similar program, presents the critical message of proper vaccinations to individuals. Seniors don't always realize that there is much that they can do to improve their own health. This program educates seniors about what they can do. It not only improves their knowledge and ability to help themselves, but also provides the facility with an additional check so that they may provide the best of care. And, it does not cost the facility anything. This program is also available to community dwelling seniors.

Some of my other programs include "Update on Long-term Care Regulations," "Putting the Pieces Together: Long-term Care Regulations" and "Assisted Living and Senior Care Pharmacy: Navigating a New Course." These programs inform healthcare professionals and facility owners/managers about the changes in regulations and how to deal with them in a manner that provides good or better patient care while containing cost. The response to these programs has been very positive. No one likes bureaucracy, so knowing what is really important in meeting regulations without wasting time on the non-important is very valuable. We are trying to help our facilities do exactly that. We highlight both care improvements and mandatory requirements, minimizing the efforts our clients make in non-regulated, non-care issues.

I also provide programs that directly yield better patient care. In pain management, which is one of my focus areas, I have provided "Management of Chronic Pain" and "Management of Non-Malignant Pain" seminars purely to improve patient care. Senior care professionals also like these programs on pain management. Providing better care results in patients who are not suffering. This makes happier patients and caregivers. I have also presented pain management topics at ASCP sponsored consultant seminars.

I see psychoactive drugs as another critical area. "Psychoactive Drug Use without Abuse," "Identification and Treatment of Depression in the Elderly" and "Psychoactive Medication Monitoring" are programs provided to caregivers and even rest home surveyors. These drugs are used when they are not necessary and this results in unhappy patients, families and caregivers, as well as in higher costs. With proper management, this overuse can be eliminated, resulting in a win for all.

Perhaps my most important contributions are several programs on Polypharmacy. I find that drugs are frequently overused. Side effects, adverse interactions and poor selection, especially with multiple diseases, can frequently do more harm than good. We can often replace and reduce pharmaceutical use, yet dramatically improve the patient's quality of life. It may seem strange that an employee of a pharmacy would recommend reducing drugs, but it often works out better for all. The family or government program saves money, the facility provides better healthcare and the pharmacy becomes a much better and desirable supplier. Most of all, the patient benefits.

Holladay's quarterly newsletter, Holladay Happenings, informs clients about events, people and technology that improve their performance. In addition to coordinating its production, I have written several Holladay Happenings articles including "Beat the Bug," which covers the benefits of flu and pneumonia vaccine for both client's staffs and residents, and "Risk Factors and Treatment of Osteoporosis," which is important for readers. Fortunately we have good professionals at Holladay who contribute articles and focus on quality care.

As Director of Clinical Program Development, I am also responsible for installing Holladay's new consulting software. I select and troubleshoot software that helps save time preparing consults, provides better summaries and reports for client facilities, and allows for future updates.

Besides developing programs and working at Holladay, I have also taught at Central Piedmont Community College and I serve as a preceptor for the Universities of both North and South Carolina and for Campbell University. I was a consultant to the Presbyterian Hospital Sub-Acute Unit, and I serve as a reviewer for the Medicaid DUR Board. I am a member of the Senior Vaccination Season Coalition, a recipient of the Eli Lilly Leadership in Education Award, and past-president of the North Carolina Association of Consultant Pharmacists. I am also a Certified Geriatric Pharmacist, a Fellow in ASCP, serving on ASCP's National Educational Affairs Council, and a long standing member of NCAP/NCPhA.

About the Author...

Margaret Sgritta, RPh, FASCP, CGP, is a member of the NCAP Board of Directors and can be reached at moffiex@aol.com.

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October 29-31, 2001, Sheraton Greensboro Hotel at Four Seasons

MONDAY, OCTOBER 29

1:00-2:30 pm	Board of Pharmacy hearing on proposed new regulations
3:00-5:00 pm	House of Delegates / NCAP Business Meeting
5:00 pm	Awards Ceremony
6:00 pm	NCAP Reception
7:00 pm	Leadership Dinner, open to all attendees

TUESDAY, OCTOBER 30

6:30-8:30 am	Satellite Symposium (TBA)
8:00-8:45 am	Carolina Seminar Program - Registration & Continental Breakfast
9:30 am	NCAP Auxiliary Meeting/Lunch at the Grandover Resort

Morning Session:
Medication Safety/IOM Report: Where are We Today?

8:45 – 9:45 am	*Preventing Medication Errors in the Acute Care Setting*, Margaret Dempsey Clapp, MS, Director of Pharmacy, Massachusetts General Hospital
9:45 – 10:45 am	*Promoting Medication Safety* *- In the Community Pharmacy Setting*, Bruce Roberts, BSPharm, Leesburg Pharmacy *- In the Acute Care Setting*, John M. Kessler, PharmD, BCPS, Duke University Health System, Durham, NC
10:45 – 11:00 am	Break
11:00 – 12:00	Panel Discussion: *Practitioner Experiences* Moderator: John M. Kessler, PharmD, BCPS C. Ellen Williams, MBA, Director of Pharmacy, Mission St. Joseph's, Asheville, NC Melissa W. King, PharmD, Medication Safety/ Quality Improvement Pharmacist , Duke University Health System, Durham, NC Bruce Roberts, BSPharm, Leesburg Pharmacy Mark Gregory, BSPharm, Director of Pharmacy Services, Kerr Drug, Durham, NC
12:00 – 1:30	Lunch & Exhibits
1:30 – 4:30 pm	**Afternoon Concurrent Sessions**

A. Pharmaceutical Care for Seniors

The Fleetwood Project: Improving the Quality of Care for Seniors, Kathleen A. Cameron, RPh, MPH, Executive Director, ASCP Foundation, Alexandria VA

Financing Pharmaceutical Care for Seniors, Gina A. Upchurch, RPh, MPH, Executive Director, Senior PHARMAssist, Durham NC

B. Implementing the Clinical Pharmacist Practitioner Act in the Acute Care Setting

Update on the ACLS Guidelines, Marc G. Reichert, PharmD, Department of Pharmacy Services, Wake Forest University Baptist Medical Center, Winston-Salem, NC

Sedation in the Critical Care Setting, Debra A. Miller, PharmD, Clinical Specialist, Critical Care, Carolinas Healthcare System, Charlotte, NC

C. Implementing the Clinical Pharmacist Practitioner Act in the Ambulatory Care Setting

Update on Anticoagulation Therapies, Wendy H. Everhart, PharmD, Therapeutic Solutions, Raleigh, NC

Smoking Cessation Methods: An Evidence-Based Review of What Works, Peter G. Koval, PharmD, BCPS, Assistant Pharmacy Director, Greensboro AHEC, Assistant Professor, UNC School of Pharmacy

Headache Management, Randall L. VonSeggern, PharmD, BCPS, President & Director, PharmQuest, LLC, Greensboro, NC

D. General Pharmacy Issues

New Drugs – The Last Six Months, Randall B. Shafer, PharmD, Eastern Carolina Drug Information Center, Pitt County Memorial Hospital, Greenville, NC

Pharmacy Law Update, David R. Work, JD, Executive Director, NC Board of Pharmacy, Carrboro, NC

4:30-6:00 **Exhibits, Residency Showcase & Reception**

WEDNESDAY, OCTOBER 31

6:30 – 8:30 am	Satellite Symposium (tba)
8:00 – 8:45 am	Registration & Continental Breakfast

Morning Session:
Current Issues in Pharmacy Practice

8:45 – 9:45 am	*Three Therapies of Life*, R. Glen Ward Jr., Consultant, Columbia, SC
9:45 – 10:45 am	*Current Issues in Medication Adherence*, Penny S. Shelton, PharmD, BCPP, FASCP, Program Coordinator, Senior Care Pharmacist, The MEDS Program, Resources for Seniors, Inc., Raleigh, NC
10:45 – 11:15 am	Break
11:15 – 12:15 pm	*Ethical Issues at the End of Life*, C. Glenn Pickard, MD, Professor of Medicine, UNC School of Medicine, Chapel Hill, NC
12:15 – 1:30 pm	Lunch & Exhibits
1:30 – 4:30 pm	**Afternoon Concurrent Sessions**

A. Herbal and Nutritional Issues in Pharmacy Practice

Evidence-Based Use of Herbal Medications, June H. McDermott, MSPharm, MBA, FASHP, Clinical Assistant Professor, UNC School of Pharmacy, Chapel Hill, NC

Current Issues in Patient-Assessment and in Promotion and Use of Nutritional Products, Sandy Bodenhamer, PharmD, Department of Pharmacy, Wake Forest University Baptist Medical Center, Winston Salem, NC

B. Issues in Acute Care Pharmacy Practice

The Current and Future Role of Radioimmunotherapy in the Treatment of Non-Hodgkins Lymphoma, Neil A. Petry, RPh, MS, BCNP, FAPhA, Assistant Research Professor in Radiology, Director, Section on Radiopharmacy, Duke University Medical Center, Durham, NC

An Update on the Management of Sepsis, Elizabeth Dodds, PharmD, Clinical Specialist, Infectious Disease, Duke University Medical Center, Durham, NC

C. General Pharmacy Practice Issues

Identifying and Treating the Impaired Pharmacist, David Marley, PharmD, RAS, Executive Director, NC Pharmacist Recovery Network, Inc., Winston-Salem, NC

Personal Digital Assistants (PDAs) in Support of Pharmacy Practice, John M. Kessler, PharmD, BCPS, Assistant Director of Pharmacy Services , Duke University Medical Center, Durham, NC; Julie Gouveia-Pisano, PharmD, BCPS, Clinical Education Consultant, Pfizer Inc., Holly Springs, NC

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First House of Delegates to Meet

According to the Bylaws of the North Carolina Association of Pharmacists, the House of Delegates is our policymaking body. NCAP will initiate this process at the 2001 Convention. On Monday, October 29 at 3:00 pm, the first House of Delegates session will be held at the Sheraton Greensboro Hotel. Delegates representing each Practice Forum, Local Association, and each School of Pharmacy including Deans and Student Delegates, will meet to adopt rules of operation, act on policy recommendations and review amendments of the NCAP bylaws. President-Elect Ross Brickley will serve as Speaker for the first House Session. During this session the House of Delegates will elect a Speaker and a Speaker-Elect for 2002.

Auxiliary to Hold Business Meeting

During the NCAP Convention, the NCAP Auxiliary will hold a business meeting on Tuesday, October 30 at 9:30 am at the Sheraton Greensboro Hotel. The meeting will be followed by a luncheon at the Grandover Resort in Greensboro. The Auxiliary has agreed to help plan the Monday night Leadership Dinner, which is open to all members of NCAP. They are also collecting special items for a raffle and sale to be held during the Convention. If you would like to donate items such as artwork, needlework, homemade goodies, crafts, and collectibles, please send them to NCAP by October 25.

Deadly Customs from the Homeland

by David R. Work

One country, two systems. Most people identify that phrase with China as it melds the capitalism of Hong Kong with communism on the mainland. Many would be surprised to learn that we have two systems for consumer access to prescription drugs in this country: one for the Hispanic community and a different one for all other consumers. This is completely contrary to the principle of equal treatment for all citizens inherent in our society.

The normal procedure for access to prescription drugs in the United States includes a visit to a physician followed by a prescription order filled by a pharmacist. Hispanics in their native lands often have no physicians available so they self-diagnose their conditions and obtain pharmaceuticals at food stores known as Tiendas. Along with tacos and piñatas they brought this self-treatment custom with them from their homeland.

Physicians in this state complain that Spanish-speaking patients arrive at emergency rooms with unprescribed antibiotics, steroids and even controlled substances. Every hospital is obliged to treat patients who arrive under emergency conditions. Charges not covered by health plans are absorbed and contribute to increased costs in health care. This Latino population is a new and growing burden on hospitals with much of it caused by their unorthodox and unsupervised use of pharmaceuticals.

One fundamental fact of drug use is that there is an immense difference between oral and injectable products. A patient who is in distress from an adverse reaction to an oral product can have their intestinal tract evacuated on both ends if necessary. This is uncomfortable but effective in removing the offending product from the body. Drugs administered by injection, however, are virtually impossible to remove once inside the skin. Treatment is much more difficult and sometimes it is not possible to save the patient from an adverse reaction from an injected drug.

Part of the transplanted Hispanic culture is self-diagnosis followed by the use of injectable drugs. This results in very powerful antibiotics such as Lincocin and Gentamicin being used indiscriminately without a competent diagnosis. Serious allergic reactions or runaway infections and deaths have resulted from using the wrong antibiotic to treat an infection. Even the injectable steroid Phenylbutazone, which can only be used in horses in this country, is available for human use at Tiendas.

The Food and Drug Protection Division of the North Carolina Department of Agriculture has state jurisdiction over this conduct and has investigated complaints on this activity. When their investigators were stalked by an obvious criminal element they wisely retreated to re-evaluate their procedures. These dedicated civil servants are not trained to deal with or expected to confront this kind of intimidating behavior.

Complaints filed for selling this contraband have come from Raleigh, Winston-Salem, Gastonia, Hickory, Morganton and Conover. The Burke County Sheriff raided a store twice and seized over 75 products including controlled substances. There are now nearly 400,000 Hispanics in the state, a population about the size of Greensboro and Winston-Salem combined.

This practice of distributing contraband drugs at Latino food stores must stop before serious damage is done. Recently in California a young boy died from ad hoc treatment with illicit Mexican drugs. The coroner found that the child would be alive today had standard health care been applied. At least two other children had the same fate. I urge physicians, nurses and pharmacists who encounter patients who have used these illegal products to contact their congressional representatives on this issue.

These products are obtained from wholesalers operating in California and south of the border. This is an interstate and international matter which needs to be addressed by the Food and Drug Administration (FDA) without delay. If FDA is unwilling to tackle this problem, then there's only one fair course. Congress should then move to eliminate the prescription requirement for drugs, except for narcotics, so that our system will conform with Mexico and yield their substantially lower drug prices. It is fundamentally unfair to have two very different drug distribution systems in health care based on ethnicity. ❖

Tips from the Carolinas Poison Center...

- Pharmacists should be aware that not only are some Hispanic/Latino food stores selling medications, there have also been cases in other states of Asian herbal remedies containing prescription medications.
- Some folk remedies and imported medications have been shown to contain contaminants such as lead, mercury, and arsenic.
- Patients combining "traditional" remedies with legal prescription medications are at risk for drug-herb or drug-drug interactions.
- Pharmacists should ask patients what OTC and traditional remedies patients take when counseling on new prescriptions.
- **The Carolinas Poison Center, the state-designated poison resource, is available 24-hours a day to assist in identifying and managing potential dangers from imported or traditional medicines. The emergency number is 1-800-848-6946.**

About the Author...

David R. Work, JD, is Executive Director of the North Carolina Board of Pharmacy in Carrboro. He can be reached via e-mail at drw@ncbop.org

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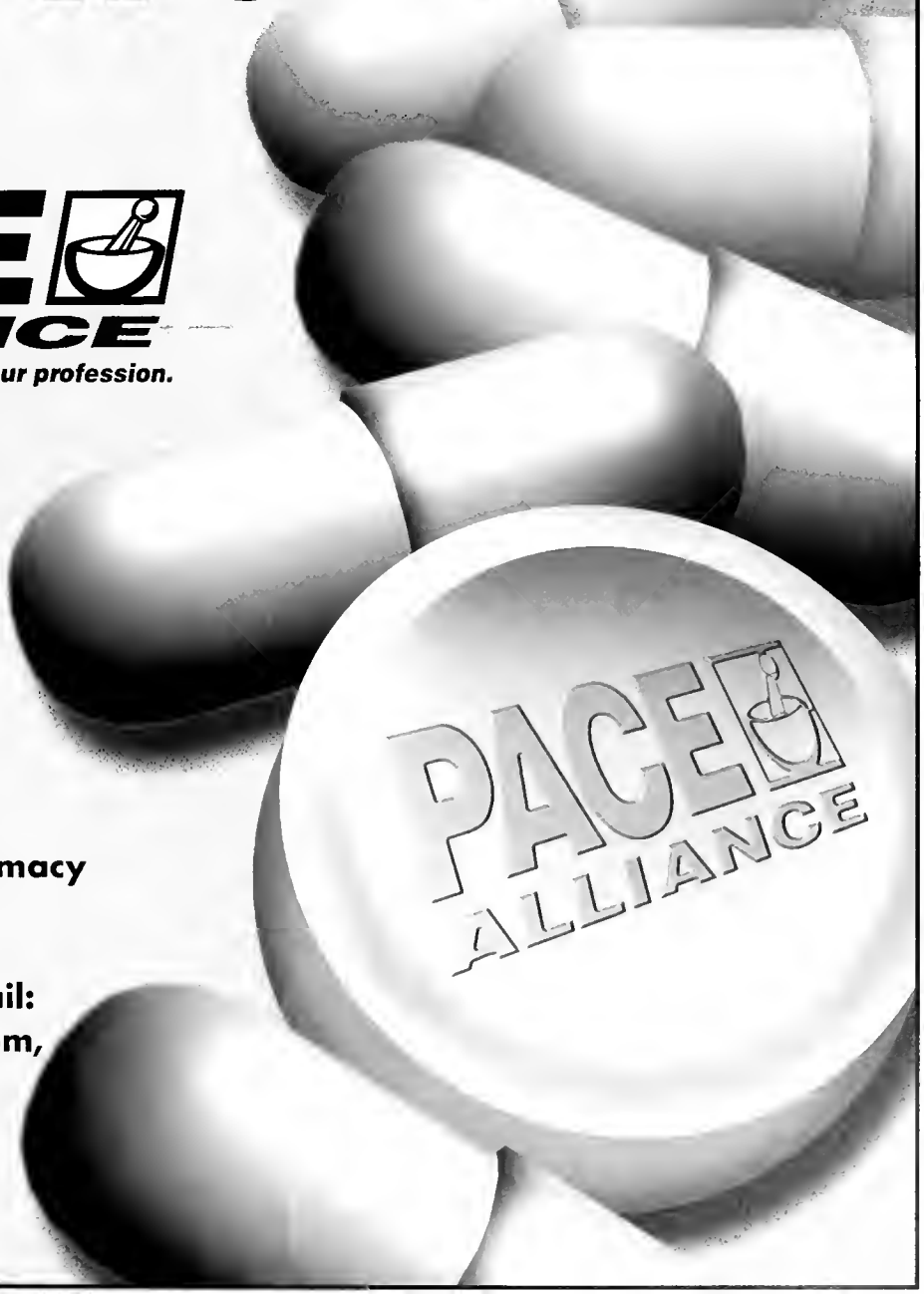

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Medication Assistance Program Improves Quality of Life

by Julianna Parrish

With a generous $1.9 million grant from the Moses Cone-Wesley Long Community Health Foundation, the Guilford County Department of Public Health's Medication Assistance Program began providing prescription assistance to patients in July, 2000. The three-year pilot-project serves residents of the Greater Greensboro area whose household incomes are below 140% of the Federal Poverty Level (one-person household $1002/month, two-person household $1355/month), and who have no form of prescription insurance coverage. The Medication Assistance Program (MAP) ensures these patients have consistent access to their medications for the chronic diseases of asthma, diabetes, high blood pressure, and heart disease. MAP hopes to demonstrate that providing prescription medications to low-income individuals suffering from these chronic diseases can improve quality of life while actually reducing total healthcare utilization and costs.

The program was initially staffed with four pharmacists (two being pharmacy residents) and one social worker, but the MAP staff has changed for the upcoming year. This year we will be staffed with three pharmacists (one being a pharmacy resident), an office specialist, and a part-time social worker. In addition to staff changes, the program will open an on-site pharmacy to further give patients convenient access to their medications. The new pharmacy should open by this Fall.

Patients are evaluated during an initial consultation where financial and medication records are reviewed to determine eligibility for the Medication Assistance Program. Eligible patients then return for a follow-up visit in one month, and their pharmacy card must he re-certified every six months. Depending on the patients' control of their disease(s), they may also choose to return every month or three months for disease education sessions. At each visit, the pharmacist checks the patient's vitals and offers disease education and medication review. MAP uses Pfizer Health Solutions' database, InformaCare, to track patient outcomes.

The four disease states were selected because they have a higher incidence among lower income patients and can be controlled with prescription medications. Patients enrolled in MAP can have their formulary prescriptions filled through a network of retail pharmacies for an $8 monthly co-pay. To stretch the limited resources, MAP utilizes both donated sample medications and manufacturers' patient assistance programs to cut program and patient costs even further. As of March, 2001, the MAP staff had saved their patients over $148,000 in retail prescription expenditures in nine months alone!

MAP Staff (l to r) Mary Elizabeth Batten, PharmD, Tuyet Le, PharmD, Julianna Parrish, PharmD, Melissa Hardy, BSW, and Julie Pittman, PharmD.

The Medication Assistance Program has served over 300 patients in the Greater Greensboro area during the first nine months of enrollment. Of these patients, 74% have been Medicare-eligible and 26% had no insurance or insurance with no prescription coverage. Thus far, the program has seen statistically significant reductions in hemoglobin A1Cs and diastolic blood pressures along with a statistically significant improvement in patients' physical quality of life.

The entire staff has learned a tremendous amount regarding lower income patients' access to medications during the past year. We have assisted many more senior citizens than projected and less working poor. Because of this, we have seen multiple diagnoses within the chronic diseases and with that, more complex medication regimens have been evaluated. We have also had enrollment challenges this year and expected a bigger demand in the Greater Greensboro area. But the staff has made up for lower enrollment with more applications to patient assistance programs and the MAP staff submitted 3.8 applications per patient enrolled during the first nine months.

Due to these unexpected challenges, along with difficulty in recruiting two pharmacy residents for 2001-2002, we have adjusted our staffing for the upcoming year. We hope to free up our professional staff and have an office specialist assist in the completion of patient assistance program applications. We also plan to open our on-site pharmacy to increase utilization of donated sample medications to further decrease program costs.

We hope to continue to increase our enrollment and are making attempts to reach those populations currently served, in addition to the Hispanic/Latino community. During the upcoming year, we will also be faced with sustaining funding and soliciting financial resources to ensure our program's future.

Working with the Medication Assistance Program during the past year has been very challenging, but rewarding. Although we have had disappointments in enrollment and staffing issues, the staff knows everyday when leaving work that they have improved someone's health and life! We have many more avenues to explore and things to learn, but we have many more patients to assist.

About the Author...

Julianna Fine Parrish, PharmD, is the Director of the Medication Assistance Program at the Guilford County Dept. of Public Health in Greensboro. She can be reached at jparris@co.guilford.nc.us

Reimbursement for Asthma Care Devices Through State of North Carolina Health Care Plans – *An Important Step for the Pharmacists to Help Their Asthma Patients*

Leslie Proctor,PharmD; Leigh Foushee, PharmD;
Roy A. Pleasants, PharmD, BCPS Campbell University
School of Pharmacy and Duke University Health Systems

The purpose of this article is to provide pharmacists with information about the process of providing patients with spacers for use with their metered dose inhalers and peak flow meters. Specifically this paper will address Medicaid, State Health Plan, and Health Choice (aka CHIPs) programs. According to the 1997 National Asthma Education Program Expert Panel 2 Guidelines for the Diagnosis and Management of Asthma, patients with moderate or severe persistent asthma should monitor their symptoms with the daily use of a peak expiratory flow meter. It is highly desirable that patients with moderate to severe-persistent asthma monitor their best peak flow daily for two to three weeks while doing well clinically. Thus, with worsening symptoms or at certain high-risk times, such as allergy season, the patient has a baseline peak flow to help monitor their asthma control in an objective manner. Patients may be able to identify a "developing" asthma flare with peak flow monitoring before they are subjectively aware of symptoms. The peak flow meter can also gauge responses to changes in drug therapy.

The use of spacers is generally recommended in young and old patients, other patients who have poor metered dose inhaler technique, as well as patients using inhaled glucocorticoids. These devices may enhance drug delivery by reducing systemic absorption, thereby reducing the incidence of adverse effects. In addition, the spacer may help compensate for poor MDI technique, a common problem. Some spacers require prescriptions and others do not, and there are differences among states with regards to the need for a prescription to get a spacer. Spacers should not be used with any dry powder inhalations.

Data is not available to describe how often patients use spacers or peak flow meters in North Carolina. Within the Oregon commercial insurance and state health plan, it was determined only 44% of moderate to severe asthma patients owned a peak flow meter with 79% of those individuals reporting compliance with the device.[1] Data on spacer use is difficult to identify in the literature, but one might assume that the number of patients owning a spacer device and those using them on a regular basis would be disappointing.

One plausible explanation for these dismal statistics is pharmacists are not billing Medicaid or other insurers for these devices, perhaps because they are unaware of how to successfully submit claims for reimbursement. The process is not difficult, it only requires time and a commitment to patient care.

For a pharmacy to be eligible to bill for these devices, they must first be enrolled as an authorized DME provider with Medicaid. If your pharmacy is providing insulin syringes to Medicaid patients, then you are enrolled as a DME provider. If your pharmacy is not currently enrolled, you can call Medicaid Provider Enrollment at the Division of Medical Assistance for information.

The patient would first present a prescription for the device. The pharmacist must be able to justify the need for the device. This requirement could be satisfied by obtaining the ICD-9 code (International Classification of Diseases 9th edition) from the prescriber for the asthma diagnosis. Once the product has been labeled, it is dispensed to the patient for no charge. For reimbursement, the pharmacist must complete and submit a HCFA 1500 form or bill via an online DME billing software. It is important to note the DME billing number should be utilized when billing for these devices and not the pharmacy provider number. The HCPCS codes needed for processing of the peak flow meters and the spacer devices are A4614 and A4627, respectively. Two peak flow meters can be billed for each patient per year at a maximum reimbursement of $25.60. Patients are eligible to receive three spacers with or without facemasks per year at a rate of $35.37 per device.

Additionally, the certificate of medical necessity and prior approval form (CMNPA) should be completed and filed for the purposes of an audit. The types of information necessary for completion of the CMNPA include patient demographic information as well as some cursory information regarding the patient's medical and functional status.

The HCFA 1500 form is available for any medical supply wholesaler and the CMNPA forms are available through the Medicaid EDS (electronic data service). All the paperwork is valid for the one-year life of the prescription.

Regarding two other healthcare plans, the State Health Plan and Health Choice (also known as CHIPs) do provide for some payment. Spacers and peak flow meters are covered by the State Health Plan and NC Health Choice under the supply benefits. Supplies with NDC numbers can be transmitted to AdvancePCS electronically and which are then forwarded to BCBS as the Claims Processing Contractor. State Health Plan members claims for these supplies would be reimbursed directly to the member: so the member would pay up-front. NC Health Choice claims are paid directly to the provider.

The impetus for the development of this article was a local Nurse Practitioner, who commented pharmacists are not providing asthma patients with the necessary devices. The reason cited was they are not aware of the process to provide spacers or peak flow meters, despite Medicaid and some other insurer's willingness to pay. Let's eliminate this kind of criticism of pharmacists and help our asthma patients by ensuring they have the devices needed to optimally manage their condition.

Medicaid Division of Medical Assistance 919-857-4017.
Medicaid EDS 919-851-8888 or 800-688-6696.

Reference

1.Mendenhall AB, Tsien Ay. Evaluation of physician and patient compliance with the use of peak flow meters in commercial insurance and Oregon health plan asthmatic populations. Annals of Allergy, Asthma, and Immunology 2000;84:523-527.

We would like to acknowledge Melody Yeargan, P.T., with Medicaid Medical Policy group for her contributions to this endeavor.

Clinical Corner

What is a Typical Long-term Care Pharmacy?

by Caroline Lewis

The practice of pharmacy has seen many changes over the past decade and long-term care pharmacy is no different. PharMerica of Waynesville is an example of a typical long-term care pharmacy. This practice site was formerly an independently owned subsidiary of a retail practice and was purchased by a national provider (PharMerica) in March of 1998. I came on board in 1988 as a staff pharmacist fresh out of pharmacy school and relatively clueless with regard to long-term care pharmacy. I saw the confusion and frustration brought about by OBRA '87 (Omnibus Reconciliation Act), a regulatory change that reshaped the role of the consultant pharmacist in long-term care. Unfortunately, most of the services provided by LTC pharmacies are due to the need to meet a regulatory requirement. Our site provides pharmacy services to skilled nursing facilities, intermediate care facilities for the mentally retarded, adult care homes, group homes, and assisted living facilities. Our services include provision of medications and related pharmaceutical supplies, I.V. services, medical records, consulting, and billing services. Facilities have the option to customize their services to include extra programs or simply accept the basics.

The staff at the Waynesville site is very dedicated to meeting the needs of our customers and their patients. Most of the pharmacists and technicians are involved in activities in the pharmacy and in the facilities. By developing an understanding of both environments we feel both the pharmacy staff and the consulting staff can respond appropriately to the needs of our customers. This also factors into our strong commitment to provide our customers with the highest quality product in a cost effective manner, using innovative thinking to achieve both.

The attention the media has given to medical errors has only emphasized the need for pharmacies to be very proactive in creating a system that protects their patients. By employing multiple internal checkpoints and forcing delineation of tasks we have come very close to eliminating our external errors. The safety of our patients is number one. However, we feel we must also focus on developing a system that protects our staff from inadvertently releasing a drug related problem to a client. Orders are reviewed by a pharmacist for accuracy and appropriateness. Our computer system screens for drug allergies, drug interactions, duplication of therapy, and potentially inappropriate use of drugs in the elderly. The order is then released to the pharmacy for dispensing.

In the pharmacy the medication is pulled by NDC codes. A technician packages the medication accordingly and affixes the prescription label and appropriate auxiliary stickers. The technician does a final check to ensure accuracy and then delivers the final product back to a pharmacist to be checked. The finished product is checked off the facility delivery record and placed in a facility specific tote after the pharmacist has completed the final check. By utilizing a simple yet very structured workflow that involves delineation of tasks, and by employing many of the extra "perks" within our computer system, we have been able to greatly reduce internal errors and almost eliminate external drug dispensing errors.

After being dispensed, the next arena for concern lies within the facilities we service. We monitor medication storage, administration and documentation. We must ensure appropriate medication use including diagnosis, dose, duration, and making sure that necessary monitors are in place. For the most part this is done by the consultant pharmacist during the monthly visit to the facility and patient drug regimen reviews. The consultant attends at least quarterly Continued Quality Improvement or Quality Assurance meetings in the facilities they service. Consultants also provide inservices for the facility staff on medication related issues. They are available either in the facility or by phone during state or federal surveys. The consultants generally act as the liaison between the facility and the pharmacy.

In the past most pharmacist interventions were done by the consultant during retrospective drug regimen reviews in the facility. As expected, pharmacist interventions occasionally create some turmoil among the medical staff, but for the most part are appreciated as assistance in patient monitoring. As the industry has evolved it has shown that prospective reviews and interventions could prevent medication related problems and be more cost effective. This was further enhanced by the implementation of Medicare's prospective payment system as opposed to the traditional cost-based system. The need to be cost effective was more apparent than ever. We appointed a clinical assessment pharmacist to review potential admissions for problems that could be prevented prior to the initial dispensing. Furthermore, until now formularies had not been utilized to any great extent in the LTC market. The need was obvious, and both dispensing and consultant pharmacists had to become key players in formulary management.

The next step in the more recent evolutionary process of the pharmacists' role in LTC pharmacy came with the implementation of the new HCFA regulations that went into effect in June of 2000. Pharmacists now have a list of drugs, drug combinations and drug disease combinations that are considered "potentially inappropriate in the elderly." This created another need for prospective reviews and possible interventions prior to the dispensing of the medication. The pharmacist had to become the "gate keeper" in this process. New orders must be screened for problems that could place a patient "at risk" based on the new regulatory guidelines. The screening process in our pharmacy is partially computer driven and partially pharmacist driven. The screening and any interventions take place in the first part of the workflow prior to the order being released to the pharmacy for dispensing.

Now we are being challenged with yet another means by which the pharmacist can participate in the care provided to our patients. The most recent approval of the pharmacy rules for a Clinical Pharmacist Practitioner in North Carolina is a welcome addition for many senior care pharmacists. Though this facet of pharmacy practice in LTC facilities has not been developed at our site, it is easy to see the benefits of such a program. By developing strong relationships with the attending physicians the pharmacists will be even more involved in the care we provide to our patients. The ability to make prospective prescribing decisions will further enable us to enhance the quality and cost effectiveness of the medical services our patients receive.

About the Author...

Caroline Lewis, BS, is General Manager of PharMerica of Waynesville. She can be reached at CML7064@pharmerica.com

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First Community Residency in NC Receives ASHP/APhA Accreditation

The Campbell University Community Pharmacy Residency Program, which includes Central Pharmacy in Durham, Kerr Drug Enhanced Pharmaceutical Care Center in Benson, and Ward Drug Company in Nashville, will be recommended for accreditation to the ASHP Commission on Credentialing at its August meeting. This will be the first community pharmacy residency program to be ASHP accredited in North Carolina and only the eighth in the nation. An APhA-ASHP joint residency accreditation committee visited the three sites on April 18-19 and made their recommendation to the sites following that visit.

by Stefanie Ferreri

What is a Community Pharmacy Residency?

A Pharmacy Practice Residency (with Emphasis in Community Care) is the official title of the community pharmacy residency program (CPRP). It is designed to foster the development of formal postgraduate education and training experiences for pharmacists in innovative community pharmacy practice settings. The program strives to develop creative and innovative pharmacy practice leaders equipped to meet the challenges presented by the rapidly changing health care system, the implementation of pharmaceutical care, the explosion of drug and therapeutics information, and the needs of society for improving patient care and monitoring of therapeutic outcomes. Key components of the residency experience are the advancement of the pharmacy profession and the discovery of new knowledge, which leads to improved patient care.

Community Pharmacy Residents and Preceptors: Front Row: (l to r) Valerie Britt, Resident at Kerr Drug, Inc., Leigh Foushee, Resident at Central Pharmacy, Michelle Childs, Preceptor at Ward Drug Company of Nashville, Inc., Stefanie Ferreri, Resident at Ward Drug Company of Nashville, Inc. Back Row: (l to r) Gil Steiner, Dir. of Community Pharmacy Residency and Preceptor at Kerr Drug, Inc., Jennifer Burch, Preceptor at Central Pharmacy, Laura Brewer, Preceptor at Ward Drug Company of Nashville, Inc., Rebecca Chater, Group Manager of Clinical Services at Kerr Drug, Inc., Larry Swanson, Professor and Chairman, Department of Pharmacy Practice.

The one-year residency provides an opportunity for the pharmacist to:

- Provide direct patient care in the community pharmacy practice environment;
- Refine their skills in communications, patient care, health and wellness promotion, practice management, marketing and compensation strategies, and technology;
- Work with preceptors, pharmacy faculty, and other health professionals whose personal and professional goals include the advancement of the profession of pharmacy and to life-long learning in the environment in which they practice;
- Engage in practice-based research which leads to new knowledge about the beneficial and adverse outcomes of drug therapy or supports the provision and benefits of community are services; and
- Gain the experience and abilities needed to prosper professionally in a competitive health care system.

What experiences have you had?

I am currently finishing the residency at Ward Drug Company of Nashville. My past year has enabled me to develop a wide array of skills necessary to practice pharmaceutical care in a community setting. Some of these activities include patient care services in the areas of diabetes, dyslipidemias, hypertension, asthma, osteoporosis, and natural hormone replacement. We have a compounding center that fills many prescriptions. We also specialize in selling and fitting patients for durable medical equipment. Other areas that I have participated in are nursing home reviews, precepting pharmacy students, and teaching responsibilities with both schools of pharmacy in the state. I was also able to work collaboratively with physicians at our lipid clinic in Rocky Mount as well as at the Open Door Clinic in Raleigh with my preceptor, Michelle Childs.

Affiliated with Campbell University School of Pharmacy, I have had an opportunity to develop a broad range of teaching skills through didactic lectures and assisting my primary preceptor, Laura Brewer, with her elective course and precepting pharmacy students. I have been a teaching assistant at the University of North Carolina's pharmaceutical care skills labs for two semesters. One of my many goals throughout this year have been to enhance my teaching skills, and this residency has given me a wonderful opportunity to do so.

The experiences I have had during the past year have been truly positive. I feel I achieved the goals I set for myself. My goals were to enhance skills in providing patient care in a community setting, investigate the reimbursement process for these activities, become involved in academia, communicate effectively with other health care professionals, and become aware of the opportunities available to pharmacists in community settings. Upon completion of this residency I feel I have advanced beyond the basic knowledge I had at graduation. I can now practice in a broad range of settings based upon the experiences I have had, which is why I would encourage anyone to complete a residency.

About the Author...

Stefanie Ferreri, PharmD, is a Pharmacy Resident at Ward Drug Company in Nashville, NC. She can be reached at spratola@yahoo.com

NCAP MEMBER SURVEY RESULTS

NCAP conducted a Member Survey during the 2001 Annual Winter Meeting in March. The following is a list of survey results. Key findings confirm that NCAP's Three-Year Strategic Plan is on track. "Communicating the value of pharmacy and the role of the technician to the public" is a top priority for NCAP in 2001. Sixty percent of those surveyed strongly agree that this plan is important to themselves and to their practice. Most members surveyed also agree that the NCAP leadership is in tune with current practice challenges and is addressing issues that will improve their ability to practice pharmacy.

1. I, as a Pharmacist, am fairly represented by NCAP?
Strongly disagree 1%
Disagree 7%
Unsure 20%
Agree 41%
Strongly agree 16%

2. My pharmacy practice setting is fairly represented by NCAP?
Strongly disagree 2%
Disagree 6%
Unsure 31%
Agree 41%
Strongly agree 13%

3. NCAP addresses issues that affect my daily work?
Strongly disagree 1%
Disagree 8%
Unsure 21%
Agree 42%
Strongly agree 25%

4. Certification programs such as diabetes, asthma, and immunization are valuable to me?
Strongly disagree 4%
Disagree 11%
Unsure 18%
Agree 41%
Strongly agree 25%

5. NCAP has articulated a clear vision of the future of pharmacy?
Strongly disagree 0%
Disagree 9%
Unsure 22%
Agree 42%
Strongly agree 21%

6. NCAP addresses issues that improve my ability to practice pharmacy?
Strongly disagree 1%
Disagree 7%
Unsure 18%
Agree 51%
Strongly agree 20%

7. My primary connection to organized pharmacy is through NCAP?
Strongly disagree 4%
Disagree 14%
Unsure 18%
Agree 40%
Strongly Agree 20%

8. NCAP provides educational programs that I can use in my daily work?
Strongly disagree 1%
Disagree 9%
Unsure 15%
Agree 40%
Strongly Agree 26%

9. The NCAP website is a valuable resource?
Strongly disagree 4%
Disagree 6%
Unsure 39%
Agree 36%
Strongly Agree 9%

10. The NCAP Journal is a valuable resource?
Strongly disagree 1%
Disagree 14%
Unsure 34%
Agree 39%
Strongly Agree 9%

11. The NCAP E-news updates are a valuable resource?
Strongly disagree 1%
Disagree 8%
Unsure 39%
Agree 35%
Strongly agree 11%

12. Passage of a Pharmacy Technician Bill is important to me and my practice?
Strongly disagree 7%
Disagree 9%
Unsure 12%
Agree 35%
Strongly agree 39%

13. The Clinical Pharmacist Practitioner Act is important to me and my practice?
Strongly disagree 4%
Disagree 5%
Unsure 22%
Agree 31%
Strongly agree 32%

14. Implementation of the Uniform Prescription Card is important to me and my practice?
Strongly disagree 5%
Disagree 13%
Unsure 25%
Agree 25%
Strongly agree 28%

15. Communicating to the public the value of the Pharmacist and role of the Technician is important to me and my practice.
Strongly disagree 5%
Disagree 1%
Unsure 7%
Agree 24%
Strongly agree 60%

16. Preservation of the present dispensing fees for medicaid and the state health plan is important to me and my practice?
Strongly disagree 7%
Disagree 4%
Unsure 28%
Agree 31%
Strongly agree 24%

17. Reimbursement for clinical services is important to me and my practice?
Strongly disagree 1%
Disagree 2%
Unsure 15%
Agree 31%
Strongly agree 46%

18. I am aware that NCAP is working on items 12-17?
Strongly disagree 5%
Disagree 6%
Unsure 9%
Agree 36%
Strongly agree 39%

19. NCAP leadership is representative of all practice settings?
Strongly disagree 5%
Disagree 9%
Unsure 25%
Agree 45%
Strongly agree 14%

20. NCAP leadership is in tune with current practice challenges?
Strongly disagree 4%
Disagree 6%
Unsure 19%
Agree 53%
Strongly Agree 15%

21. I would recommend to other Pharmacists and Technicians to become an NCAP member?
Strongly disagree 5%
Disagree 5%
Unsure 11%
Agree 35%
Strongly agree 36%

Unique Team Combines Information Resources

Briefly describe your overall practice?

I am the Assistant Director for Pharmacy Information Services and Research at the University of North Carolina Hospitals and Clinics. In this capacity, I am the leader and manager of acute and ambulatory care information systems and automation technologies, the UNC Center for Drug Policy and Research (Drug Information), the UNC Center for Medication Safety, and the UNC Investigational Drug Service.

by Rowell Daniels

What unique services do you provide?

As a leader, I help establish the long-term vision of each of my areas of responsibility. As a manager, I act as a facilitator and remove barriers for the members of my team. Combining the role of leader / manager results in four broad themes to my practice: 1) that my immediate staff and the broader departmental staff have the information systems tools and resources to be effective in their jobs; 2) that we make information easily available for clinical and administrative decision-making; 3) that information systems and automation are always highly available and reliable; and 4) that we are taking an "open-eyed" approach to developing safe and effective medication systems.

How did you determine the need for these services?

I credit our Director, Jim McAllister, for having the vision to create this unique team that combines drug information resources with information systems resources. Significant results have been achieved by melding the priorities of these two areas.

Here are some examples:

Too many times clinicians and pharmacy administrators are faced with making decisions based on limited information. Even if the information is available, it's located in multiple locations and / or difficult to obtain. Information should be easily accessible. When I first arrived at UNC, even our drug information group had a difficult time accessing information. Over the past year alone, we have developed a departmental web site on our hospital's intranet, implemented an on-line formulary, and developed simple reporting tools for extracting drug use evaluation (DUE) data. This has allowed our "Drug Information" group to begin its conversion to a "Drug Policy" group. With 60 clinicians, 12 residents and 120 student rotation months per year, we ask a lot of questions. My teams ensure that there are answers.

In addition, information systems have, of course, become the lifeblood of everything we do. It's imperative that these systems are consistently reliable. Information systems issues that do arise should be effectively dealt with in as short of a time frame as possible. We have assembled a team of five pharmacists who are devoted to maintaining and expanding the use of our numerous information systems. We have also partnered with the Hospital's Information Services Division (ISD) to develop a highly trained Pharmacy and ISD on-call team to support Pharmacy IS needs around the clock.

The Department of Pharmacy also coordinates Medication Safety initiatives at UNC Hospitals. We have assembled a Medication Use Safety Committee, designed a new reporting mechanism, and as a result of the data generated from this system, have implemented numerous safety initiatives.

How did you develop your practice to meet these needs?

All of these practice initiatives are human resource intensive. They are in areas that have not traditionally come by support easily. To gain support, it has been essential to develop relationships and deliver results.

For example, we have worked very hard at developing a relationship with the UNC Department of Risk Management. As a result, Risk Management has turned all management of adverse drug event reporting over to the Department of Pharmacy. Also as a result of effectively managing a pilot Pediatric Medication Safety Program, the Department of Pharmacy has been awarded three new positions for the upcoming fiscal year to expand the Safety Program to the entire institution. This results in five positions (two others coming from a grant and an internal reallocation). The five positions (one nurse, one pharmacy technician, and three pharmacists) will coordinate all Medication Safety initiatives through the newly established UNC Center for Medication Safety.

All of my other practice areas have taken similar paths and had similar experiences in their establishment and growth.

What lessons have you learned as a result of this experience?

For someone in my position, it is important to have a strong working relationship with members of the Legal, Risk Management, Continuous Quality Improvement and Information Services Departments. Taking the time to establish these relationships and build trust has allowed us to gain support in critical areas of need.

Don't assume that non-clinical IS support personnel understand the clinical importance of pharmacy information systems. Take the time to explain how pharmacy systems directly impact patient care. The time invested will pay for itself when the unexpected crisis arises.

Pharmacy should take THE leadership role in medication safety initiatives. As pharmacists, we have the unique opportunity of being in the middle of the medication use process. This offers us a great vantage point when it comes to clinical and operational medication safety leadership.

Information for decision-making should be accessible by all staff (pharmacists, technicians, billing clerks, etc.). If they don't exist, tools should be developed to aid in this process.

Combining drug information resources with information systems resources has produced and will continue to produce

great results for our department.

Where are you heading now with your practice?

There are numerous, ever evolving clinical information systems roles for pharmacists at UNC (Prescriber Order Entry, Web-based Electronic Medical Records, etc.). One of my main goals is to ensure that pharmacy has a presence and therefore influence on these systems as they are being developed.

We also continue to formalize the role of the UNC Center for Medication Safety. Through this group and in cooperation with Boards of Pharmacy, Nursing, and Medicine, we aspire to develop a State of North Carolina Collaborative Group on Medication Safety. This Collaborative will act as a clearinghouse for patient safety initiatives within the State of North Carolina. With a focus on North Carolina's laws and regulations and benchmarking "best practices," the intent is that this group will provide pertinent medication safety information to North Carolina's Hospitals, Community and Retail pharmacies, Clinics and health care practitioners.❖

About the Author...
Rowell Daniels, MS, PharmD, Assistant Director, Department of Pharmacy, UNC Health Care System can be reached at RDaniels@unch.unc.edu

NCPhA Endowment Fund Dinner to Become Annual Event

Jane and Keith Elmore enjoy the festivities at the North Carolina Pharmaceutical Association Endowment Fund Dinner held Saturday, May 19 at the Carolina Club in Chapel Hill. Keith is President of the Endowment Fund, a charitable foundation established in 1989. Its purpose is to support the North Carolina Association of Pharmacists with annual grants to be used for scientific, literary, and educational purposes. The Fund is administered by a nine-member Board of Directors and is funded by donations. Your support is critical to the success of the Fund. If you would like to make a tax-deductible contribution to the Endowment Fund please send a check, made payable to the NCPhA Endowment Fund, to NCAP, 109 Church Street, Chapel Hill, NC 27516.

Should all Technicians be Nationally Certified?

by Debbie LeGrow

Having recently graduated from the Pharmacy Technology program at Durham Technical Community College, I felt it would be in my best interest to take the National Certification Exam because it would give potential employers a clear indication of my level of training and education. It was an important personal goal, and one that I feel all technicians should consider. In addition, with the impending changes in legislation which give more authority and greater scope of practice to the Pharmacist, the responsibilities, and therefore the level of training, will also expand for the pharmacy technician. I have a special interest in IV preparation and I knew that it would be essential for me to complete an accredited course in Pharmacy Technology if I was to be considered for employment in this area. I believe that by acquiring Certification, I will give hospital management the opportunity to utilize my knowledge and expertise anywhere in inpatient pharmacy.

As the role of the pharmacist continues to expand, allowing for more patient contact and consultation, the role of the pharmacy technician must also change. Pharmacists will have to rely on pharmacy technicians to take on added responsibilities, especially in the dispensing aspects of the pharmacy. Pharmacists are quick to share that they prefer technicians to be certified because they can feel confident in the technicians' abilities, thereby allowing them to focus their attention in other areas. I know there are many "veteran" technicians employed today, some for more than 20 years, who do not wish to take the certification exam. But, if we are to be recognized for the specialized work we perform and show management that we are capable of handling more responsibility, therefore commanding higher salaries, then we must prove ourselves highly trained and worthy of such increases and changes. The Certification Exam provides a national standard by which the potential pharmaceutical employer can confidently place demands upon the technician with minimal added training or orientation.

It is also apparent that, due to the general consensus that earnings associated with the pharmacy technician position are insubstantial, both in retail and hospital settings, it has caused many in this field to terminate their employment and return to school to pursue other career paths. This has resulted in a shortage of trained and certified pharmacy technicians. The law of supply and demand will cause an upward pressure on the pay scale of all pharmacy technicians. Adding the nationally certified credential will further increase the pay scale and open up more demanding positions in the field.

Although the label "pharmacy technician" refers to all technicians, delineation should be made between the retail technician and the inpatient hospital technician. Retail technicians are not required to work in a sterile environment and therefore are not trained in this area. The IV room technician must learn how to prepare precise IV admixtures in a sterile environment using correct aseptic techniques in order to ensure efficacy and safety to the patient. Technicians must be specially trained in pharmacy calculations and preparation techniques in order to be employed in this area. The retail technician does not work in this environment, but must be able to accurately interpret prescription orders, deal with insurance companies and clients, and dispense medication to the community they serve. In each setting, the pharmacy technician must be adequately trained in order to perform their duties accurately and safely.

The National Certification Exam covers a pharmacy technician's role in all pharmacy settings. If retail technicians have not graduated from an accredited Pharmacy Technology program, they are clearly at a disadvantage and will require education and training by the Pharmacist and/or retail chain. Retail chains now offer employees a training program in order for them to successfully pass the National Certification Exam. The proposed technician legislation in North Carolina will allow the Board of Pharmacy to expand the technician to pharmacist ratio beyond 2:1, provided the additional technicians are nationally certified.

We, as pharmacy technicians, need to be recognized as experts in our field and I feel that acquiring National Certification is a step in the right direction. The practice of Pharmacy will continue to evolve in the coming years and as it broadens, the scope of duties performed by the Pharmacist will in turn add significant responsibilities and change the role of pharmacy technicians. At this time it is not mandatory for pharmacy technicians to be certified, but if we are to be duly recognized in our field, then it is my opinion that all technicians should acquire National Certification.

About the Author...

Debbie LeGrow is a pharmacy technician at the University of North Carolina Hospitals in Chapel Hill. She can be reached at dleg39@aol.com

Pharmacy Technician Survey Preliminary Results

As part of our continuing effort to better serve pharmacy technicians in North Carolina, NCAP is conducting a Pharmacy Technician Survey. Please visit www.ncpharmacists.org to participate in this important survey. Final survey results will be posted on the NCAP website when a sufficient sampling has been achieved. To date, 63 technicians have responded to our survey and the following is a list of preliminary results.

1. How long have you been employed as a pharmacy technician?

Average:12.5 years

2. Which of the following best describes your primary work setting?

Community: 27%
Hospital: 46%
Long-term care: 9.5%
Other: 17.5%

3. What is your current salary?

Certified Technicians: $12.67 per hour
Non-certified Technicians: $11.29 per hour
Overall Average Salary: $12.30 per hour

4. Do you currently hold a pharmacy technician certification?

73% Yes
27% No

5. Check which of the following methods best describes the means by which you became a pharmacy technician.

On the job training: 79%
Community college curriculum: 21%

6. Check each of the following that best describes your duties.

84% assist with dispensing
59% compounding
51% mix IV's
52% perform other duties

7. How many hours per year of Continuing Education do you attend?

Average: 12 hrs. per year

8. Please list any continuing education topics that you feel would be beneficial?

Most requested topic: Pharmacy Law

9. Would you be interested in serving as an NCAP Technician Council member?

25% Yes
60% No
15% Did not respond

UNC Awards Day Celebration

Craig Anthony, PharmD (r) receives the T.R. Burgiss Family Award from Associate Dean Pamela Joyner at the School's Awards Day Celebration on May 6, 2001 at the Morehead Ballroom. Craig is a 2001 graduate of the UNC School of Pharmacy where he served as Vice-President of his class. He received the Award for his essay highlighting the profession of pharmacy in action. He has accepted employment with Winn-Dixie Pharmacy in Morganton, North Carolina.

2001 Calendar

August 29: ***Clinical Pharmacist Practitioner Act Program: A Model for Pharmacists and Physicians to Help Optimize Patient's Drug Therapy,*** 1:00 - 5:00 pm, Sheraton Imperial, Research Triangle Park. For more information visit www.ncpharmacists.org or call 1.800.852.7343.

September 8-9: ***16th Annual Pharmacy Practice Seminar,*** Wilmington Hilton Riverside. For more information e-mail sherrie_moore@unc.edu or call 919.966.1128.

October 29-31: ***NCAP Annual Convention and Carolina Seminar*** Sheraton Greensboro Hotel at Four Seasons. Topics include Pharmaceutical Approaches to Infectious Disease Therapy, Medication Errors, Prevention and Detection. For more information visit www.ncpharmacists.org or call 1.800.852.7343.

Please visit the NCAP website at www.ncpharmacists.org for more information on upcoming meetings and events.

Small Doses

Pharmacists Mutual Announces Discount for Association Members

Pharmacists Mutual Insurance Company announces a new discount available to association members. Members are now eligible for a premium discount on a Lincoln Benefit Life Company long-term care policy. Pharmacists Mutual Insurance Company has arranged for this discount through its subsidiary, Pharmacists National Insurance Corporation. The discount is 15% for applicants 40-64 years of age and 10% for ages 65-84. For more information about this valuable member benefit program please call Pharmacists Mutual at 800-247-5930, ext. 706 or visit our website: www.phmic.com (this is not a claims reporting site).

Currently licensed in 34 states, Pharmacists Mutual has been providing exceptional products and professional service to the pharmacy profession since 1909.

Eight Campbell Residents Present at Regional Meeting

Three community pharmacy residents, two geriatrics, two primary care and one drug information resident presented seven different projects at the thirty-second annual Southeastern Residency Conference on April 26th and 27th in Athens, Georgia. These residents joined approximately 220 others in making this the largest residency conference to date. The conference, held each spring at the University of Georgia, provides a forum for residents and preceptors to share ideas on a regional level, as well as providing valuable experience in presenting original work. Residents presenting were evaluated by the audience on communication skills, presentation style, and project design. The Campbell residents worked throughout the year on their projects and refined their presentations in front of the faculty to continue the tradition of excellence at this meeting.

Pharmacists Mutual Elects Board Members, Names President

The annual meeting of the board of directors of Pharmacists Mutual Insurance Company, Algona, Iowa was held April 27, 2001. Kirk M. Hayes, CPCU was elected Chairman and Chief Executive Officer and Edward T. Berg, MBA, CPA, CPCU was promoted to President and Chief Operating Officer.

Hayes joined Pharmacists Mutual in 1963 and has served as President of the organization since 1975. Berg joined Pharmacists Mutual in 1977 and has served as Executive Vice President since 1987. He was elected to the board of directors in 1994. All other officers were reelected to the same positions previously held.

Two directors were re-elected to the board at the annual meeting: Kirk Hayes of Algona, IA, as well as Richard H. Williams, RPh, of Lancaster, Pennsylvania. Newly elected to the board was Earl W. (Bill) Bradley, RPh, FACA, of Sugar Land, Texas. All were elected to a three-year term.

Margaret Randall of the NCAP Auxiliary recognizes Campbell University scholarship recipient Amanda Lee Bryan.

Campbell University Commencement

The 2001 School of Pharmacy graduates at Campbell University were awarded PharmD degrees on Monday, May 14th. Albert Lockamy, Jr., Past-President of NCAP, Past-President of the North Carolina Board of Pharmacy, North Carolina Pharmacist of the Year, and a CVS Pharmacist, was awarded an Honorary Doctor of Science degree. His keynote address at the Hooding Ceremony provided valuable guidance to Campbell's pharmacy graduates.

North Carolina

NCAP

Pharmacist

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If you're not a member of NCAP you're missing half the picture

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Seventy-Five Years Ago, We Were An Independent Pharmacy, Too.

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North Carolina Pharmacist

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Inside

Fred Eckel
Executive Director

Pharmacy's Future Depends On Your Long-term Investment

Long-term investments seem to be of little interest today. We seem to live for today and not for tomorrow. Membership in NCAP is primarily a long-term investment because we are making decisions today that affect pharmacy's future. Yes, we are trying to protect and enhance our present activities. Dispensing pharmacy is important to us and will continue to get our attention. Drug therapy management is also important, and we will continue to promote pharmacists' role in this too. Keeping balance between emphasizing the present and promoting the future is not easy, and I pledge my efforts at doing both well. My belief is that we must do both, and I believe that NCAP is the best means to do this. But we can only accomplish this if we represent enough North Carolina pharmacists. When we tell people that NCAP represents all pharmacists in North Carolina, we get their attention. If they realized that only 20% of North Carolina pharmacists are members, their attention would quickly divert. Today, the issues facing the pharmacy profession are not only of interest to pharmacists. Legislators, health policy-makers and other health professionals are also interested and involved with many of our issues. That is why it is so important to have a credible and effective voice to tell pharmacy's story.

Pharmacists must define their own future and defend their present activities. Since most pharmacists are now employees, do they feel that others will take care of their professional and employment needs? Is that why they haven't joined NCAP?

Perhaps NCAP may not be doing what you want and need, so you feel that your membership is wasted. However, NCAP will only change from within. So, if you want different programs, join and promote change in the organization.

Pharmacists have been squeezed enough. We have little more to give. What's the best way to get this message out? Who is the best messenger to deliver this message? I believe that NCAP, as the organization representing all pharmacists, is in the best position to develop pharmacy's message and communicate it most effectively - but only if we represent a majority of pharmacists.

This will not be the last Journal published by NCAP, but it could be the last communication to all North Carolina pharmacists. NCAP must focus on meeting its members' needs, bringing its budget in balance and doing well the programs we have already committed to. Just when Legislators, health policy-makers, and the medical professions seem to be "getting it," NCAP's visibility may shrink. I don't want that, and I don't believe you do either. By the end of this year my focus and NCAP's will move from membership growth to membership support. I hope you will elect to join now so you can be part of our effort to create pharmacy's future. ❖

An NCAP Membership Application Can Be Found on Page 23.

Letter to the Editor

To the Editor,

During my residency I had the opportunity to work with some of the finest pharmacists in the state. As a young pharmacist, I sincerely appreciated their mentorship and value their friendship. Amidst the many clinical fundamentals I learned during this training, I learned probably the most important lesson of all - Be Involved.

Throughout pharmacy school, I did not join many professional organizations, after all, what could one person do? Well, once I graduated and began my residency I quickly discovered that one person could do a lot. In addition to my preceptor, Dan Garrett, Beth Williams, Rebecca Chater and many others showed me the value of being a leader in the profession.

Now, I am an advocate of the Association and encourage pharmacists and technicians to join and learn the lesson I have learned. I have also taken a stand with political issues affecting pharmacists by writing letters and encouraging others to do the same. I realize these are baby steps for some, but to me they are large steps in the right direction.

I have enclosed a donation to the association in honor of my residency preceptors: Bill Burch, Jennifer Burch, and Sloan Barber, as a thank you for the professional values instilled in me during my residency training. Please accept this gift to advance the profession of pharmacy in North Carolina and continue its growth.

Professionally yours,
Leigh Foushee, PharmD
Clinical Pharmacist

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William L. Harris, Jr
President, NCAP

Dear NCAP members and potential members,

With the help of many pharmacists, technicians and staff, NCAP accomplished most of the established goals for 2001. But we can accomplish much more with your help. NCAP was founded to represent all pharmacists in North Carolina, but many pharmacists are missing. I appeal to your professional responsibility as a pharmacist to join NCAP, the voice of North Carolina pharmacists.

North Carolina pharmacists have always been leaders in organizing, advancing and representing the pharmacy profession to the public. There has been a state pharmacy association in North Carolina since 1882, when the North Carolina Pharmaceutical Association (a founding member of NCAP) was created "to unite the pharmacists of this state for mutual aid, encouragement and improvement, ...to develop pharmacy talent and to elevate the standard of professional thought." In 2000 NCAP was founded on these same principles, again to unite all pharmacists in North Carolina to have "one voice, one vision." We must continue that tradition.

I had the privilege to speak to several pharmacy student groups this year about NCAP, pharmacy issues, where the profession is going and NCAP's role. I ask you to think back to your feeling of pride and joy about pharmacy when you entered pharmacy school and when you graduated. Remember the expectations, high aspirations, excitement, and desire to help patients with their medications? We need to recapture the enthusiasm and motivation of a new graduate in our approach to the profession.

Many pharmacists experience similar enthusiasm and encouragement through active participation in the state association. NCAP provides (1) professional challenges, (2) opportunities to change practice, (3) forums to actuate drug therapy changes in patient care, (4) contacts to seek improvements, (5) networks of experienced and talented practitioners, (6) meeting places, (7) continuing education conferences, (8) a stage for sharing and much more. These opportunities and challenges allow pharmacists to get out of their "silo" and become involved in actions to advance pharmacy practice as far as their dreams allow. Time and commitment are needed for participation, but working with others to achieve professional success is uplifting, confidence building and rewarding. Lessons learned and shared experiences will enrich and enlarge the "silo" in which we practice and broaden our view of the profession.

NCAP needs all pharmacists in North Carolina to join the Association. We need your talent, energy, knowledge, experience, vision, problem-solving skills, professional goals and support. Through your participation, NCAP can understand your situation and professional needs and best represent your voice to the public, the legislature, state leaders, other healthcare practitioners, healthcare payers and others who impact our profession.

The pharmacy profession changes both by input from practicing pharmacists and by external forces. We cannot survive and advance the profession unless we change our attitude and practice faster than the powerful external forces we encounter. Working alone to make changes is very difficult. But by working together in our professional association, there is more visibility and strength of number to overcome barriers and achieve the necessary publicity, interest and support of other practitioners and the public.

Success in the Legislature is impossible without adequate support both in number of constituents and clarity of message. Prior to NCAP, I visited senators and representatives on numerous occasions to request their support on bills or issues affecting pharmacy. Invariably within a few minutes, the question was asked, "Which pharmacy group do you represent?" This is a cunning tactic to determine how strong is the group making the request. When division is identified, it provides the legislator with an easy excuse to dismiss or ignore the request because different messages are received from other pharmacists. NCAP avoids this problem because pharmacists are united and support all areas of pharmacy practice. We will be more successful as one team, working together to communicate the value of pharmacists in providing patient care and building professional goals.

If you are already an NCAP member, thank you for your continued support and participation. If you are not, please join now to ensure that our pharmacy students and new graduates will have a strong state pharmacy association to provide them with professional guidance and leadership in the future. Be an example for them to learn from and to follow. NCAP will provide you with information and resources on professional issues, contacts with fellow pharmacists, solutions for practice problems, leadership building, champions to enhance your practice, mentors, team-building experience, professional attitude adjustment and more. The more you participate, the greater will be your reward.

Make NCAP your professional family in North Carolina. Join other pharmacists who share the same goals, dreams, visions and outcomes.

Sincerely,
William L. Harris, Jr., RPh, President

...applying drug knowledge to improve health

NCAP Membership Q&A's

Since July, NCAP Executive Director Fred Eckel has reached out to pharmacists across the state, via e-mail, as part of an aggressive membership recruitment campaign. He has received a wide range of responses and from those, we have pulled a list of questions and asked the following NCAP members to respond to these questions:

Regina Schomberg, PharmD
Pharmacy Clinical Coordinator, Internal Medicine
Wake Forest University Baptist Medical Center
Chair, NCAP Membership & Marketing Council
Bryan Bray, PharmD
Director of Clinical Services, PharMerica
Brenden P. O'Hara, RPh
District Pharmacy Manager, Eckerd Drugs
Vice Chair, NCAP Membership & Marketing Council

Q: Why are dues so high? I can join national organizations for about the same amount.

A: The cost to do research and lobbying is very high these days. There are many issues which can shape the practice of pharmacy in North Carolina evolving everyday. NCAP offers pharmacists in North Carolina the voice and power to affect these important issues. Paying dues to a national organization, while important, will not give the support we pharmacists need in North Carolina to affect the changes occurring in the practice of pharmacy.
- B. Bray

A: Of course you can join a national organization for the same amount. With that membership you receive a nice journal, tons of mailings, and an opportunity to attend national meetings. However, are you honestly making a difference in overall pharmacy practice? By being a member of the state organization, you can honestly say that you are helping to promote pharmacy in the state of North Carolina. In order for the national organizations to continue to excel, state organizations must be strong. - R. Schomberg

Q: Is NCAP doing anything to improve pharmacists' working conditions?

A: ABSOLUTELY. They have a consumer education program so patients actually know what pharmacists are doing, they have been instrumental in passing the universal drug card, they have programs to educate your technicians and help them pass the CPhT exam, they are trying to work with insurance programs to get pharmacists reimbursed for their cognitive services (Asheville project), and this is only from a community practice standpoint. - B. O'Hara

A: Workplace issues is a priority of NCAP's. Together with the North Carolina Board of Pharmacy, NCAP has led two forums focusing on issues in the workplace. The first forum held in February 2000 looked at overall problems in the workplace. The second forum held in February of this year allowed participants to discuss third-party issues. By creating a forum for pharmacists, technicians, administrators and others to discuss issues, NCAP is taking the lead on improving the pharmacy workplace. More information regarding this topic can be found on the NCAP website.
- R. Schomberg

Q: Why does my practice environment seem to be under-represented in your association?

A: Naturally everyone feels that way, when you take four different organizations that each supported nothing but one practice environment and condense them into one voice for the entire profession you would feel as though you are being slighted. However, there are practice forums within NCAP that take the individual concerns and help them get attention and become realties.
- B. O'Hara

A: Define under-represented? Perhaps your practice environment is not well known to others within the organization. Marketing begins with one person. If you feel you are under-represented, get involved, make others aware of what you do, and make a difference. - R. Schomberg

A: NCAP is doing a better job of representing different practice settings. There are many different practice forums pharmacists may join specific to their practice setting. While representing diverse areas of practice, NCAP still provides the unification required to move the practice of pharmacy forward. This unification is something that other professions always have (medicine, nursing) which allows for more power in affecting political changes. - B. Bray

Q: I already get my CE from other sources. What value are NCAP's CE programs to me?

A: The CE programs conducted by NCAP provide quality education in many aspects of pharmacy practice. As an acute care pharmacist, I get my CE from programming within my institution specific to my area of practice. However, by attending CE programs sponsored by NCAP, I receive education in other areas of pharmacy practice. By becoming knowledgeable in all areas of practice, I can continue to provide my patients in the acute care setting with the best possible care – care that crosses the continuum.
- R. Schomberg

Q: I'm not a practicing pharmacist right now, I'm working for a pharmaceutical company. What are the advantages of membership for someone like me?

A: I believe that NCAP does a good job representing all areas of pharmacy. Changes that occur on the industrial side of pharmacy do not go unnoticed by NCAP. When pharmacists from different practice settings join NCAP they have a huge network of pharma-

cists available to them. From the industrial side, especially in sales and research, being able to network is a huge advantage. - B. Bray

Q: Why is NCAP promoting technician membership?

A: *NCAP is a unified voice for the profession. Technicians are an integral part of every practice. It makes good sense to get them involved. NCAP helps them receive the education they need to pass the CPhT exam, makes them realize that they are an integral part of the pharmacy care team, and gives them a needed voice.*
- B. O'Hara

A: Technicians are vital to pharmacy practice now and in the future. We need knowledgeable, well-trained, and dedicated technicians in all aspects of pharmacy. We need technicians to recognize their role and want to excel in that role. By increasing technician membership within NCAP, we can form a core group of technicians who can focus on technician issues within the state.
- R. Schomberg

A: *With the scope of the practice of pharmacy changing everyday, and because pharmacists are becoming more involved in direct patient care, a well-trained technician staff is going to be required to allow the pharmacist to "step out from behind the counter." I believe NCAP gives technicians updates on changes of practice that affect how their jobs are going to change. It also gives technicians the opportunity to attend training programs to meet the expectations of a changing practice environment.*
- B. Bray

Q: NCAP represents the interests of employer pharmacists but not employee pharmacists.

A: I couldn't disagree more. From day one of NCAP's creation, it has been an advocate for all pharmacists. Regardless of your practice site or title, NCAP prides itself in being the organization for pharmacy in the State of North Carolina.
- R. Schomberg

A: I strongly disagree with this statement. I believe NCAP's interests do not differentiate between employee and employer pharmacists. In a lot of cases, because "employee" pharmacists do not take an active part in NCAP's affairs (and don't join!), and "employer" pharmacists do take more of an active role, it seems as though the above statement is true. I believe this should be a call to "employee" pharmacists to become the "majority" instead of the "minority" in order to have a stronger voice in NCAP.
- B. Bray

Q: I don't identify with the current practice forums because I practice in a non-traditional environment. Is there a place for me in NCAP?

A: *I currently practice in a non-traditional environment (a physician-office practice) and I strongly believe NCAP is there for me. In fact, the CPP Act supports a non-traditional practice. NCAP has been there for me to support issues that I had about the CPP Act. I also strongly believe in innovation. If a practice forum does not exist for you then I believe it is your responsibility within the profession to initiate one and I believe NCAP will support this. I strongly believe NCAP supports innovation.*
- B. Bray

Q: Convince me that joining NCAP is a good investment.

A: *Our profession of pharmacy is changing at a very rapid pace (i.e. CPP Act, senate bill introducing pharmacists as providers, potential Medicaid reimbursement reductions, drug cards, etc.) so now more than ever we need a unified, strong voice to shape our future. Medicine, Optometry and Nursing have had unified visions and voices which have shaped change within their profession. I believe it is the responsibility of each pharmacist in North Carolina, no matter what their practice setting may be, to join NCAP and move the profession forward to where we want it to be (providing adequate reimbursement for drug products, providing a framework for direct reimbursement for cognitive services, etc.).*
- B. Bray

A: *One concern that was brought up was that people who move here from other areas feel that they are outsiders. I would like to respond to that. If you move to a new area and you are looking for people to welcome you with open arms, that will not happen if you do not make an effort. I moved here from upstate New York in 1998 with a very shy attitude. I heard about the formation of the unified voice of NCAP, was intrigued, and went to some meetings but no one recognized me. Aside from the casual hello I received, no real efforts were made but none were really made on my part. I realized that what was going on with NCAP was decades ahead of what I left in New York and I wanted to help the profession grow. Through continued meetings and efforts in my professional life I was recognized. Not because I demanded it as a pharmacist, but because I earned it. Get involved, I know you will be welcomed. I can speak from experience.* - B. O'Hara

A: *Benefits of NCAP include: Involvement and support in legislative issues, quality CE programs, the opportunity to network with other pharmacy professionals, the NCAP Journal, the NCAP website, E-News for quick legislative updates, the opportunity to market pharmacy as a profession, a Mentorship Program, the opportunity to serve the organization in a leadership role, and many, many more!!*

One membership at $175 = 3.5% of a $5,000 sign-on bonus, or 0.2% of your annual salary, or one month of eating out for lunch, or one month of paying to park your car, or 25 trips to the movies. Isn't your profession worth the sacrifice? - R. Schomberg

A strong voice speaking on behalf of all pharmacy is the best way to deliver our messages, insure our future, and advance our services. There is strength in numbers. Pharmacy has been fragmented too long. We have let others take care of us. Now our situation is critical. You can only change an organization from within so if you want NCAP to move in a different direction then join and help lead us. Please fill out and return the NCAP Membership Application on page 23.

Clinical Pharmacist Practitioner Program

The Clinical Pharmacist Practitioner (CPP) Act Program was held August 29, 2001 at the Sheraton Imperial in Research Triangle Park. The CPP Act allows for a pioneering collaboration between pharmacists and physicians in North Carolina to offer consumers a new way to access healthcare and improve drug therapy outcomes. More than 225 pharmacists and physicians attended the program which was sponsored by the North Carolina Association of Pharmacists, Duke University Office of Continuing Medical Education, Campbell University School of Pharmacy, and the Triangle College of Clinical Pharmacists. The program presented representative models where pharmacists and physicians are already collaborating to improve patient outcomes. Perspectives from the Pharmacy and Medical Boards were also presented.

Jay Groce, PharmD, of Campbell U. School of Pharmacy and Moses Cone Health System, presented "Pharmacist and Physician Model in a Hospital/Clinic Setting- Anticoagulation."

The CPP Act was passed by the North Carolina Legislature in 1999 and states that pharmacists approved as Clinical Pharmacist Practitioners by the North Carolina Board of Pharmacy and the North Carolina Medical Board can work with physicians under written protocol to assist in managing a patient's drug therapy. This new law allows pharmacists to take a broader role and work directly with patients on drug therapies for chronic diseases such as diabetes, asthma and hypertension. In some instances, CPP's may have the authority to prescribe certain medications and order tests.

NCAP has estimated that of the 7,000 practicing pharmacists in North Carolina, approximately 450 will qualify to become CPP's. Of that number, many will provide a needed service by practicing in rural areas of the state where there is a shortage of physicians. Since June 22, 2001, twelve applicants have been approved by the Board of Pharmacy and the Medical Board.

If you'd like an application or more information on how to become a CPP, please contact the North Carolina Board of Pharmacy at 919.942.4454.

CPP Program Coordinator Roy A. Pleasants, PharmD, addresses more than 225 people who attended the CPP Program.

Newly Licensed CPP's

The following is a list of North Carolina practitioners who have become licensed CPP's as of October 9, 2001:

Randal L. Von Seggern, Greensboro
Bryan K. Bray, Greensboro
Stephanie M. McClain, Greensboro
Robert M. Malone II, Chapel Hill
Terry W. Laws, Asheville
Anna D. Garrett, High Point
Beth A. DeWitt, Asheville
Mary E. Bryant, Chapel Hill
Jennifer M. Bayes, Reidsville
Michelle L. Childs, Raleigh
Brian T. Peek, Asheville
Charles F. Sprinkle, Weaverville

NCAP Seeking CPP Committee Members

The CPP legislation provides an opportunity for pharmacists to expand their role. How to promote this opportunity and encourage more pharmacists to become CPP's is one of NCAP's new challenges. NCAP is proposing the creation of a new committee to focus on this goal. If you are interested in serving on this committe please contact Executive Director Fred Eckel at 919.967.2237, ext. 23.

2002 NCAP Election Results

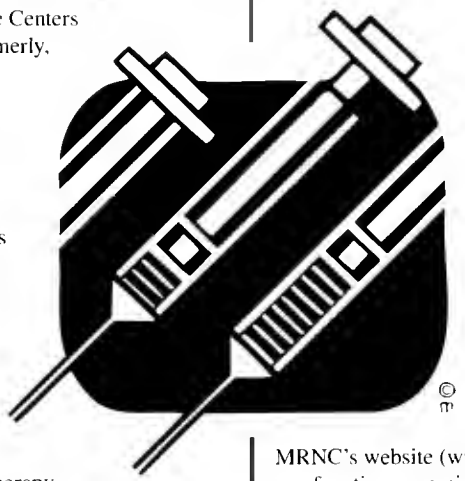
Election ballots have been tallied and the following members will serve as NCAP officers in 2002:

NCAP President-Elect:	Jack Watts
NCAP Board of Directors:	Chris Jones, Lorie Poole
Acute Care Practice Forum	
Chair-Elect:	Anna Garrett
Executive Committee:	Donald Harvey, Lorie Poole, James Worden
Ambulatory Care Practice Forum	
Chair-Elect:	Jennifer Burch
Executive Committee:	Davie Waggett
Technician Practice Forum	
Chair-Elect:	Michelle Valentine

How to Increase Vaccination Rates

by Marissa Clifford & Randee Gordon

Pneumonia and influenza combined are the sixth leading cause of death in the US and are responsible for 600,000 hospitalizations among Medicare beneficiaries each year. Pneumonia is also the cause of more than 500,000 emergency department visits by Medicare patients each year.[1,2] The incidence of pneumonia increases with age, and approximately 90 percent of pneumonia related deaths are in people aged 65 and older.[1,3] Much of the burden of these diseases can be eliminated through proper vaccinations. Although the cost of both vaccinations is covered by Medicare Part B, North Carolina immunization rates remain quite low. Overall, the influenza and pneumococcoal vaccination rates for NC Medicare beneficiaries are only 65% and 51%, respectively. Inpatient screening/administration rates are even lower (influenza, 19%; pneumococcal, 12%).[4] In May 1999, the Centers for Medicare & Medicaid Services (formerly, HCFA) launched the National Pneumonia Medicare Quality Improvement Project. The project goal is to decrease the morbidity and mortality associated with community-acquired pneumonia among Medicare beneficiaries. The quality indicators, or measurable aspects of care, of the project include both inpatient and outpatient measures that can be influenced by pharmacists. They include:



1. Increase the number of inpatients who receive timely antibiotic administration (initial dose within eight hours of hospital arrival)
2. Increase the use of initial antibiotic therapy consistent with current recommendations
3. Increase the collection of blood cultures prior to the administration of antibiotics
4. Increase the number of hospitalized patients who are screened for or given pneumococcal and influenza vaccines
5. Increase state wide immunization rates for pneumococcal and influenza vaccines[4]

Medical Review of North Carolina, Inc. (MRNC), the state peer review/quality improvement organization, has been working in inpatient and outpatient settings to increase the rates of influenza and pneumococcal immunizations among Medicare beneficiaries. Some of these efforts have included the formation of the Senior Vaccination Season Coalition, co-chaired by MRNC and the Division of Public Health. This statewide initiative is a collaboration of 40+ public and private organizations including local health departments. The goal is to increase the number of immunizations given throughout the state by targeting healthcare providers to actively educate, facilitate, and immunize all vulnerable populations. Recently, NCAP has begun participating in coalition meetings and activities. In addition, MRNC has been promoting the use of standing orders for vaccinations in an inpatient setting. Many hospitals have been successful at implementing standing orders with the assistance of pharmacist 'champions.'

Pharmacists are in a unique position to improve the health of seniors and increase statewide vaccination rates. Community-based pharmacists can implement several interventions to raise awareness about immunizations and increase vaccination rates including: distributing flyers or displaying posters in retail stores that remind patients about getting their flu shot and direct them to local clinics. Make a pledge to counsel all seniors during flu season about the importance of vaccination. When counseling patients, remember to emphasize that immunizations will help them stay healthy and active, a key motivator for seniors. Coordinate efforts with your local health department and become involved with community flu clinics and events. Hospital-based pharmacists also have an opportunity to take a proactive role in the immunization of their patients. As mentioned earlier, pharmacists have been successful at serving as project champions. In addition, research has shown that standing orders for immunizations can greatly increase vaccination rates. Consider advocating for standing orders within your own institution. Pharmacists can help ensure access to the vaccine and monitor utilization.

Medical Review of North Carolina, Inc. has several resources and tools that can help pharmacists in their immunization efforts. If you are interested in receiving free copies of patient immunization wallet cards, posters or brochures, please contact the authors or visit MRNC's website (www.mrnc.org). Patient education materials can function as reminders to patients and help facilitate discussion around immunizations. ❖

About the Authors...

Marissa Clifford, MPH, CHES and Randee Gordon, MPH are employed with Medical Review of North Carolina, Inc. a peer review/quality improvement organization. They can be reached at 1-800-682-2650.

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Consultant Pharmacy Experiencing a Revolution

by Randy Angel

Consultant Pharmacy originated in the nursing home environment more than thirty years ago when a group of innovative pharmacists identified the need to improve the use of medications for nursing home residents. Recognizing the early work of consultant pharmacists and the continued need to improve pharmaceutical care in nursing homes, the federal government enacted regulations mandating pharmacist-performed drug regimen review (DRR) in nursing home facilities and Intermediate Care Facilities for the Mentally Retarded (ICFMR).

Today more than 10,000 consultant pharmacists provide clinical and distributive services to more than 1.7 million nursing facility residents, 1.8 million assisted living residents, and hundreds of thousands of others in a wide variety of care environments.

The practice environments, opportunities, and responsibilities of consultant pharmacists have expanded far beyond the initial vision of the early innovators. Today, consultant pharmacists can be found in a wide variety of practice settings including subacute care, assisted living facilities, adult day care programs, psychiatric hospitals, hospice programs, pain management programs, correctional facilities, and in home and community based care. Innovative services continue to expand and include disease management, collaborative practice, private and physician based office practices, software development, clinical research and drug information services.

The geriatric focus of consultant pharmacy meets an important healthcare need due to the rapidly growing elderly population. The elderly are at increased risk of morbidity from drug-related problems such as adverse drug reactions, drug interactions, excessive use of medications and inappropriate duplicative drug therapy. Twenty-eight percent of hospitalizations among seniors are due to adverse drug reactions. In addition 32,000 seniors suffer hip fractures each year due to falls caused by medication-related problems. The economic impact of medication-related problems in persons over the age of 65 rivals that of Alzheimer's disease, cancer, cardiovascular disease, and diabetes. Medication related problems are estimated to be one of the top five causes of death in this age group, and is a major cause of confusion, depression, falls, disability, and loss of independence.

The impact of consultant pharmacy services on patient outcomes and healthcare costs is being evaluated in a three-phase initiative called the Fleetwood Project. Phase I demonstrated that consultant pharmacist conducted drug regimen review improves therapeutic outcomes by 43 % and saves $3.6 billion annually in costs from avoided medication related problems. Phase III of Fleetwood will identify and measure the impact of "pharmacist-sensitive outcomes" in seniors at high risk for medication related problems. Training necessary for widespread implementation of the Fleetwood model will also be refined. Phase III will involve a North Carolina based pharmacy provider and seniors living in North Carolina.

Consultant pharmacy practice provides the challenges and rewards of ambulatory care and acute care. Seniors suffer from the common diseases of the ambulatory care population including hypertension, diabetes, CHF, osteoporosis and depression. Seniors also present unique challenges including Parkinson's disease and Alzheimer's. Patients are very accessible and provide the consultants an opportunity to compile an extensive pharmaceutical database enhancing continuity of care. Long-term care also involves more traditional aspects of acute care pharmacy including drug utilization evaluation, provision of drug information to both patients and other healthcare professionals, formulary management and clinical rounds.

Although no specialized post BS Pharmacy training is required to practice senior care pharmacy, the need for comprehensive disease management skills has prompted many senior care pharmacists to pursue PharmD degrees and geriatric pharmacy practice residencies. Also, senior care pharmacists are distinguishing their skills by becoming Certified Geriatric Pharmacists. The Commission for Certification in Geriatric Pharmacy (CCGP) offers an examination in geriatric pharmacotherapy and use of medications in older adults. Over 500 pharmacists across the US, Canada, Australia and Sweden have successfully completed the examination to date.

Some say that a revolution is occurring in pharmacy practice. This is certainly true in consulting pharmacy. Our practice is shifting toward caring for seniors regardless of where they live. After all, only a small percentage of seniors actually reside in skilled nursing facilities. We must determine ways to effectively move our drug management model to seniors still living at home, receiving support at senior centers or in independent senior facilities. Several consultant pharmacists throughout the country are developing independent, consulting only practices. In some cases they are teaming up with geriatric case managers and home health organizations to identify and provide drug management services to seniors outside the traditional nursing facilities.

Consultant pharmacists must be effective oral and written communicators. You will be relied on as a drug information resource for both residents and other healthcare professionals you serve. You will be an educator, teaching your residents, their families and their nurses and physicians. You will be part of a drug management team, providing input to formulary and clinical intervention initiatives. First and foremost senior care pharmacists take responsibility for their patients' medication-related needs by ensuring that their medications are the most appropriate, the most effective available, the safest possible, and are used correctly. ❖

About the Author...

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Diabetes Education and Management at Duke

Briefly describe your overall practice.

I have been a clinical pharmacist with Duke University Health System (DUHS) since February 1999. My primary site is the Duke Outpatient Clinic (DOC), which is the main hospital-run, primary care clinic, staffed by the residents for Duke's Internal Medicine program. Approximately 80 physician interns and residents serve in the clinic under the guidance of attending physicians. I oversee clinical pharmacy operations at the DOC. Fifteen other clinical pharmacists also come to the DOC on a rotating basis. These pharmacists regularly work in other areas of DUHS, from drug information to inpatient services, and they attend clinic to diversify their practice experience. In addition to the diabetes services described here, we provide a great deal of medication assistance in the form of samples and pharmaceutical company assistance programs to over 300 patients. We work with the DOC social workers to manage these programs. I have a faculty appointment with UNC and take a number of students. We also train pharmacy residents regularly at this site.

My other clinic site is at one of the DUHS Private Diagnostic Clinics (PDC). There are eight internists who work at this PDC. I primarily provide diabetes education and management services to this practice. Scott Joy, MD has been the physician "champion" for services there, and we work collaboratively to design and manage the pharmacy services, as well as being involved with several research projects at this site.

Finally and most recently, I serve as a clinical pharmacist with the Endocrinology Consultation Service (also known as the Diabetes Management Service, DMS) within Duke Hospital, which consists of an attending endocrinologist, an endocrinology fellow, internal medicine residents or interns, a nurse diabetes educator, and myself. While this team is adept at providing consultation on any endocrinology disorders, the vast majority of patients consulted are for diabetes. These patients may have newly diagnosed or uncontrolled diabetes, or may be being placed on new insulin therapy that requires titration and instruction.

What unique services do you provide?

Diabetes education and management is the primary service I provide at all these sites. At the DOC and PDC, we have a progressive protocol established to authorize the titration of current medication doses and check laboratory measurements to monitor therapy. We meet with patients on a one-on-one basis; they may or may not be seeing their physicians at those times. We may see up to eight to ten patients per half-day, about four to five half-days per week. Pharmacy residents and students assist with evaluating these patients. I became a certified diabetes educator (CDE) in May 2000, providing me with an important credential to justify my clinical skills to the internists and endocrinologists I work with. I have run into very little physician resistance in establishing and maintaining this service, and they continue to refer new patients every day.

The diabetes program differs slightly from the DOC to the PDC. At the DOC, we offer a fairly complete multidisciplinary service: pharmacy, nursing, nutrition, and social workers all provide personal appointments for patients to instruct on diet, activity, monitoring, foot care, and community resources. At the PDC, we have a less diverse group. Other than me, only a nurse diabetes educator offers a diabetes class once a month. On the first Friday of every month at the PDC, Dr. Joy and I pair up to see diabetes patients together in what is called "disease-specific scheduling." Typically I will evaluate the patient first, then discuss their care with Dr. Joy and he will see them afterward. This is a unique model in the PDC system, and our recent data shows that this pharmacist-physician pairing results in a significant reduction in HbA_{1c}, compared to other diabetes initiatives used there in the past. At the PDC, we track patients using the computer software WinGlucofacts® (Bayer Diagnostics), enabling downloads of blood glucose meters to analyze readings in ways not possible by just reviewing a logbook.

With the DMS, my availability is limited to only two days a week, but I assist the nurse educator with patient education, espe-

cially those who are newly diagnosed or need to learn how to prepare and administer insulin. I also provide recommendations to the team during rounds regarding drug therapy or special patient care issues. I try to focus on patients who are on new medications, who need insulin instruction, or those who will be followed at my clinics so I can get enrolled in the diabetes services there. In these cases, it creates a continuity of care model, allowing me to help the patients both in the hospital and out.

How did you determine the need for these services? How did you develop your practice to meet these needs?

The diabetes services developed out of a recognized need to have organized diabetes education provided to the DOC patients, who are of lower socioeconomic status where diabetes is more prevalent. When proposed, this was met with great acceptance by the Medical Director of the clinic, as well as the other physcians. Even the endocrinologists applauded our efforts. After a short time, I was called upon by the PDC to offer a similar service through Dr. Joy, where he had an acute sense of the needs of the large diabetic population at that clinic. Both services took off rapidly without many barriers to the idea. My practice on the DMS team was initiated because the endocrinologists simply wanted a pharmacist educator on their service. We have enjoyed a tremendous amount of strong physician support for all of our chosen clinical services with diabetes. Everyone is very open-minded and recognizes that we are all on the same team, seeking common goals.

Are you being reimbursed for the services you provide?

Unfortunately, because of the hospital financial structure, we have been unable to find a legitimate method of billing for these services. However, we continue to probe and ask questions to the administration. We will be very interested to see how the Clinical Pharmacist Practitioner Act will change the structure and perspectives of those within DUHS. I hope to seek the CPP credential in the near future.

What lessons have you learned as a result of this experience?

The greatest lesson that I have learned in these practices is that a pharmacist can have a great deal of success and have a stimulating practice when one has strong support of physician colleagues and upper administration, such as in our pharmacy department. We also have such great resources here at Duke for other personnel support and continuous opportunities to expand clinical services.

Where are you heading now with your practice?

We are in the midst of training our first Ambulatory Care pharmacy resident this year, and we hope to continue that program for future years. With regard to new clinical services at the DOC, we are now starting an asthma/COPD pharmacy management clinic. This is just in its infancy, but developing with a great deal of physician support. At the PDC, our research efforts are very strong, such that we will be conducting a study looking at the difference in care between postprandial blood glucose monitoring versus traditional preprandial monitoring, in regards to HbA_{1c} control and provider interventions, with the support of a large grant from Bayer Diagnostics. This is a new and growing area in diabetes research and I am excited to be a part of it. ❖

About the Author...

Phil Rodgers, PharmD, BCPS, CDE is a Clinical Pharmacist at Duke University Health System and a Clinical Assistant Professor at the University of North Carolina. He can be reached via e-mail at Philip.Rodgers@duke.edu

Residency Builds Confidence, Improves Skills

by Dana Hayes

I chose to do a residency to gain confidence in my abilities and improve skills acquired as a student. Presentations to healthcare professionals and writing articles allow the resident to look more objectively and critically at their work in an attempt to improve communication skills. The supervision that the resident receives during the residency helps to quickly enhance abilities that were developed during pharmacy school. Practitioners and colleagues who have extensive experience are available and willing to assist residents with projects. These projects meet established goals and objectives of the residency. Residencies also provide detailed exposure to aspects of pharmacy that were not available to the student during their clerkship year. As a resident I will have an opportunity to be exposed to management aspects of hospital pharmacy in an administrative rotation. An administrative experience was not an option as a student. Overall, a residency gives the pharmacist a chance to develop skills, refine knowledge and explore new areas in a short amount of time.

A residency differs from academic training in many ways. Pharmacy school prepares the pharmacist to practice in a wide variety of settings, teaches general concepts and supplies the basic tools to survive as a pharmacist. The residency program takes this generalized learning a step further and begins to expand and improve the concepts learned during school. Application of the knowledge gained during pharmacy school can be difficult. The residency teaches residents about clinical significance compared to didactics learned in school. The resident has the opportunity to focus their attention on several key areas and learn the details of those areas. The residency also differs from academic training because the resident's clinical input and decisions make a direct impact on patients.

One of the unique opportunities in a residency is the residency project. The project lasts approximately a year. The project gives the resident the opportunity to examine one aspect of pharmacy and acquire knowledge, skills, attitudes and abilities essential for contemporary pharmacy practice. The first and hardest step is to find a topic to study that would be useful to the hospital. A formal proposal is formulated after the topic has been decided. The majority of the year is then spent collecting data and analyzing it. The project will then be presented at the Southeastern Residency Conference in Athens, Georgia. The final step is preparing a manuscript to submit to a journal for publication of the project. I am considering a project to assess the benefits of nesiritide usage in post coronary artery bypass graft patients who experience heart failure. I hope to publish the study upon its completion. This project will involve collaboration with physicians at our institution to assess benefits at this hospital, which will provide the opportunity to develop relationships with key health care providers.

The residency provides valuable experience for the resident, but the practice site also benefits from the resident. The resident receives an enhanced learning experience and the hospital improves its patient care. For example Gaston Memorial Hospital recently opened a neonatal intensive care unit (NICU). My fellow resident, April Richard, PharmD, and I have been working on NICU charts for the IV room. Another project that has been completed since we began is the establishment of a protocol for reteplase. The residency provides career benefits such as improved leadership skills, public speaking and writing.

Learning pharmacy is the first battle for the pharmacist, but practicing pharmacy is the ultimate goal. A residency provides pharmacists the tools and opportunity to apply the clinical and didactic aspects of pharmacy in order to practice pharmacy well. I would highly recommend a residency to any pharmacist who is interested in furthering their own abilities and developing their skills to practice the highest standards of pharmacy. ❖

About the Author...
Dana Hayes, PharmD, is a Pharmacy Practice Resident at Gaston Memorial Hospital in Gastonia, NC. She can be reached at HayesD@gmh.org

Whit Moose Receives Community Pharmacy Award

Campbell University's School of Pharmacy held its Sixteenth Convocation on August 29, 2001. Presenting the M. Keith Fearing Community Pharmacy Practice Award to Whit Moose, Sr. (center) was Lib Fearing (l), wife of the late Keith Fearing and Co-President of the NCAP Auxiliary, and Ronald W. Maddox (r), Dean of the Campbell University School of Pharmacy. The award is presented annually to honor outstanding leaders in community pharmacy.

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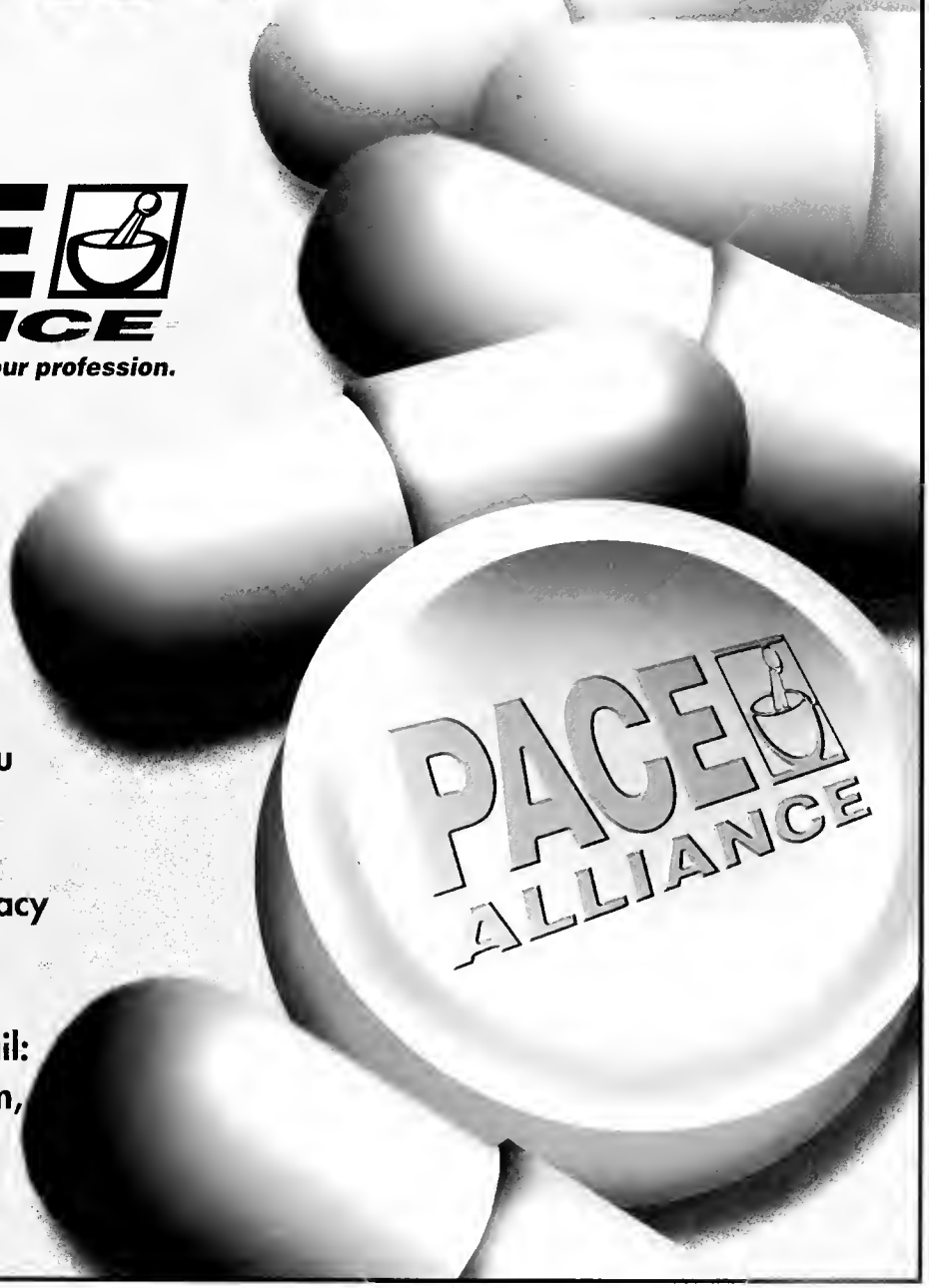

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Davidson Medical Ministries Assists Underserved

by Cathey Miller

A 42-year-old female enters Davidson Medical Ministries Clinic (DMMC) for a foot ulcer that will not heal. She is on a large dose of insulin, and her Diabetes Mellitus is not controlled. She has been in and out of the hospital emergency department five times in six months. Does this sound familiar? It was becoming too familiar in Davidson County. The Chronic Disease Clinic of Davidson Medical Ministries in Lexington, North Carolina was started in November of 2000 to help with this problem.

Davidson Medical Ministries is a medical clinic established to serve the poor and underserved population of Davidson County. The clinic provides two acute care clinic opportunities each week to see patients, and these clinics were becoming filled with patients with chronic diseases such as Diabetes Mellitus, Hypertension, and Hyperlipidemia. DMMC obtained a grant from the Duke Endowment to hire a physician assistant to see these patients, specifically those with Diabetes and Hypertension. As part of a Project IDEAL (Improving Diabetes Education, Access to Care, and Living) grant from the Kate B. Reynolds Foundation, the Free Clinic of Reidsville needed to expand to another site. Project IDEAL is a plan to provide extensive medical management and education to Diabetes patients. DMMC was chosen to be an expansion site. Sandy Motley, executive director of DMMC, combined the two efforts of these ideas and the Chronic Disease Clinic (CDC) of DMMC was formed to care for patients with diabetes and/or hypertension. The CDC is staffed by Milissa Johnson-Fitzgerald, PA-C and myself, with the support of an LPN and the supervision of Lon Morgan, MD.

Patients are enrolled into the CDC either by physician referral from the acute care clinics or after a retrospective chart review. These patients receive extensive education about their disease process and are able to obtain consistent care from a primary care provider. Scheduled follow up occurs for all patients, rather than "sick visits" only. The CDC is available in two four-hour clinics per week. As of August 2001, a total of 72 patients have been seen in the CDC. Currently, 67 patients are still actively being followed for care. Of the patients, 39 have both diabetes and hypertension.

My role in the clinic is to provide diabetes education and to assist Milissa Johnson-Fitzgerald in the medical management of these patients. Initially, all diabetes patients are seen for three consecutive weeks for intensive diabetes education. On the first visit, all patients are given a complete physical exam. They receive education on what diabetes is, complications of uncontrolled diabetes, review of symptoms of high and low blood glucose, review of treatment goals, and are provided with a blood glucose meter and instructed on its use. The second visit is dedicated to nutrition and exercise education. The third visit focuses on sick day protocol, foot care, and skin care. Baseline laboratory values are obtained on all patients including a Chem-12, HbA1c, CBC, urinalysis, microalbumin, and fasting lipid profile. Depending on disease control, follow-up visits are scheduled at six week to three-month intervals.

How are we doing? We have seen a significant decrease in acute visits to the emergency department and the acute care clinics for CDC patients. Foot problems are discovered early, and costly amputations are avoided. After six months, the average decline in HbA1c is 1.07%. All patients are being monitored for nephropathy. Seventy percent of patients have had a dilated eye exam in the past year. Seventy-one percent of patients have an LDL cholesterol level less than 130mg/dL. Additionally, we have observed an average decline in blood pressure to 132/78 from baseline. One of our proudest accomplishments is our ability to better manage drug therapy. Of fifteen patients enrolled on insulin, only eight patients remain on insulin therapy and have an HbA1c of 7% or less. Recommended drug monitoring is being provided to all patients. Patients have an average HbA1c of 7.59% after six months of care in our clinic.

The most pressing problem we have is the availability of drug therapy. Being a free clinic, the pharmacy budget is very limited. DMMC pharmacy requires donations of physician samples and utilization of indigent patient care programs to survive. Many times we have had to change drug therapy due to medication availability. Our patient population is unable to purchase the expensive medications needed to optimally treat diabetes, hypertension, and hyperlipidemia. Referrals are made to specialists who will care for indigent patients, and this limits our referral network.

Where to now? The immediate concern is sustainability of the program. All CDC staff positions are funded through grants. The Project IDEAL grant is guaranteed through 2002, and the Duke Endowment grant is guaranteed through 2003. We would like to obtain funding to provide an intensive smoking cessation program to our patients. ❖

About the Author...

Cathey Miller, PharmD, is a Clinical Pharmacist at Davidson Medical Ministries Clinic and a Clinical Consultant Pharmacist at PharMerica. She can be reached at CatheyAMiller@aol.com

2001 Recipients of the "Bowl of Hygeia" Award

Wyeth-Ayerst Laboratories takes great pride in continuing the "Bowl of Hygeia" Award Program developed by the A. H. Robins Company to recognize pharmacists across the nation for outstanding service to their communities. Selected through their respective professional pharmacy associations, each of these dedicated individuals has made uniquely personal contributions to a strong, healthy community which richly deserves both congratulations and our thanks for their high example.

Wyeth-Ayerst Laboratories, Philadelphia, Pennsylvania WYETH-AYERST LABORATORIES

Clinical Corner

Unnecessary Antibiotics In Respiratory Tract Infections: Teach Patients To "Just Say No!"

by Richard H. Drew

The inappropriate use of antibiotics has been identified as a major contributing factor to the development of bacterial resistance. The consequences of such resistance include increased morbidity and mortality, treatment failures, increased length of hospital stay, and increased cost of care.[Tenover F. Clin Infect Dis. 2001;33(suppl3):108-113.]

Recent attention has focused on the inappropriate prescribing of antibiotics for many respiratory tract infections. Based on data from the 1998 National Ambulatory Medical Center Survey, it was estimated that 76 million primary care office visits in the US occurred for acute respiratory infections resulting in 41 million antibiotic prescriptions. (Gonzales R et al.Clin Infect Dis. 2001;33:757-762) Of these, 55% were inappropriate, leading to unnecessary health costs of $726 million.

While physicians are generally aware of the need for prudent antibiotic prescribing, lack of published treatment guidelines, coupled with diagnostic challenges in differentiating bacterial from noninfectious or nonbacterial (i.e. viral) respiratory tract infections, often present significant challenges. Beyond these medical issues, physicians perceive pressures from third-party payers and patients to prescribe antibiotics in attempts to satisfy patient's demand for prescription medications.

Efforts are underway at state, national and international levels to address the problem of increasing pathogen resistance through promotion of prudent antimicrobial use. In support of this effort, consensus guidelines on the management of pharyngitis, sinusitis, unspecified respiratory tract infections and acute bronchitis have recently been published to assist prescribers in identifying clinical situations where antibacterial therapy is not indicated (available on the web at http://www.annals.org/issues/v134n6/toc.html.) (see Table 1) These guidelines were endorsed by the Center for Disease Control, American Academy of Family Physicians, American College of Physicians, American Society of Internal Medicine, and the Infectious Diseases Society of America. While dissemination of these treatment guidelines is a valuable part of optimizing antimicrobial therapy, further emphasis needs to be placed on reducing the demand for unnecessary antibiotics by educating patients and patient advocates (such as parents and guardians of young children) regarding the hazards and costs associated with such abuse at both a personal and societal level. An important step in reducing inappropriate antibiotic prescribing for respiratory tract infections is the severing of connections between patient satisfaction and antibiotic prescribing. Although patients often expect to receive an antibiotic when seeking advice from a physician, such expectations are often generated by their past experience under similar circumstances. (Gonzales R. Am J Med.2000;108:83-5; Hamm R. J Fam Pract. 1996;43:56-62)

Recent evidence has demonstrated that patient satisfaction may relate more to the patient-centered quality of the encounter rather than the antibiotic prescription (Gonzales R. Am J Med.2000;108:83_5.) Consistent with this approach are the programs conducted by the CDC, which advocate that health care providers be involved in advising patients of the consequences of unnecessary antibiotics for treatment of viral illnesses. The illness should not be dismissed as "only a viral illness." Rather, the CDC's program encourages the development of "active treatment plans" (such as the use of "care packs" containing agents for relief of symptoms), an explanation as to a reasonable time course of a viral infection, and action plan if symptoms do not resolve within a reasonable time frame. Active involvement of other health care providers (such as nurses and pharmacists) is also encouraged.

Pharmacists can play in integral part in promoting the appropriate use of antibiotics. Pharmacists practicing in ambulatory care settings must assume the role of patient advocate, becoming involved in education. Patients must be informed that allergic reactions, adverse effects, drug-drug interactions, unnecessary medical costs, and subsequent infections with resistant bacterial strains are all potential consequences of unnecessary antibiotics. In support of efforts by physicians and pharmacists to educate patients regarding the hazards of inappropriate antibiotic prescribing, the CDC has compiled both practitioner and patient-oriented educational materials which are available from their website (http://www.cdc.gov/ncidod/dbmd/antibioticresistance/materials.htm).

In addition to their role as educator, pharmacists in these settings can provide patient triage to patients seeking self-care products for respiratory tract infections, advocating higher risk patients or those who are medically unstable to seek appropriate medical care. Pharmacists in institutional practice settings may have opportunities to provide prescriber feedback regarding adherence to published treatment guidelines through continuous quality improvement initiatives or drug use evaluation programs.❖

About the Author...

Richard H. Drew, PharmD, MS, BCPS is a Clinical Pharmacist (Infectious Diseases) at Duke University Medical Center and Associate Professar at Campbell University School of Pharmacy.

Table 1. Respiratory Tract Infections for Which Antimicrobials are Not Indicated

Indication	Recommendations
Sinusitis	NO ANTIBIOTICS for mild-moderate disease
Acute Bronchitis	NO ANTIBIOTICS regardless of duration of cough
Pharyngitis	Treatment limited to patients most likely to have group A beta-hemolytic streptococci infections. NO ANTIBIOTICS for all others
Upper respiratory tract infections (unspecified)	NO ANTIBIOTICS in previously healthy adults

Source: http://www.annals.org/issues/v134n6/toc.html

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NCAP Instrumental in Passing Tech Bill

by Dan Garrett

Recently an insurance company executive asked me, "how are pharmacists going to have time for their increased clinical role?" What was interesting to me is that he recognized the value of pharmacists as patient care providers, but he also knew that the current systems for filling prescriptions do not allow pharmacists the time needed to help patients. I was asked this question the same day that the Governor signed into law the bill establishing the Pharmacy Technician as a recognized member of the healthcare team in North Carolina.

The recognition of Pharmacy Technicians in statute is a watershed event in advancement of pharmacy in our state. At the NCAP Leader's Forum on pharmacy workplace issues in February 2000 one of the items recognized as a top priority was the enhanced role of the pharmacy technician. Out of the Leader's Forum grew a consensus opinion that NCAP should work towards passing a bill that would create recognition and opportunities for pharmacy technicians.

The NCAP Legal and Public Affairs Council, under the leadership of Ross Brickley, worked hard in the year 2000 to develop language for a proposed bill. The strength of our unified state pharmacy organization allowed for input from the diverse opinions of independent, hospital, chain and consultant pharmacists to be melded with those of technicians and the Board of Pharmacy to create a unique approach to training and recognition for pharmacy technicians.

The new law allows those who are already working as technicians to continue in their role and encourages pharmacy technicians to achieve national certification. Standard items for technician training are identified, while the pharmacist-manager is allowed flexibility to develop site specific training programs. Those who want to use higher technician ratios are permitted to do so under provisions that give the Board of Pharmacy the authority to insure safe systems for medication dispensing. Technicians are also now included in the Pharmacist Recovery Network. A key to the bill's success was the ability of NCAP to balance interests and achieve compromise positions.

A key to passing this bill was the attendance of pharmacists and technicians at Pharmacists' Afternoon in the Legislature held in February of this year. The counsel and support of our lobbying firm, Alley and Associates, aided passage of this bill. NCAP leadership has learned that all of pharmacy must work together and approach the legislature with a professional and unified voice. In fact, the two primary bill sponsors, Senator Purcell and Representative Allen have now had success with both the Clinical Pharmacist Practitioner Act and the Pharmacy Technician Bill and are willing to help pharmacy with future issues that are in the public's best interest.

Based on our collective success in passing this bill I think we need to start developing a bill for 2003 to answer the insurance executive's next question, "are pharmacists now recognized for payment for clinical services?" ❖

About the Author...
Dan Garrett, MS, is Senior Director of Medication Adherence Programs for the American Pharmaceutical Association Foundation.

Techs Have A Red Letter Day

A Pharmacy Technician Red Letter Day was August 17, 2001, the day Governor Easley signed legislation recognizing the entity of Pharmacy Technicians. As with all newborns, we will have to go through many stages of development.

We had a very, very long gestation period, but we have arrived. To some it may seem like we arrived silently, just opened our eyes and breathed. Some may think we are loud, protesting fetuses that preferred the womb. Others feel we are noisy, arms flailing, feet kicking, active creatures ready to conquer the world. Anyway you want to look at it, we are here to stay.

As Pharmacy Technicians, we are in our infancy. We now need to grow and investigate this world we have joined. The first step in our development is the acknowledgment that we are "person(s) who may, under the supervision of a pharmacist, perform technical functions to assist the pharmacist in preparing and dispensing prescription medications."

Our second stage of development requires us to meet the

basic standard of having a high school diploma (or equivalent) or to be enrolled in a program that will award us one.

The third stage of our development will span a period of no more than 180 days. During this time we will be trained to handle pharmacy related duties by acquiring knowledge and skills, including but not limited to pharmacy terminology, pharmacy calculations, dispensing systems and labeling requirements, pharmacy laws and regulations, record keeping and documentation, and the proper handling and storage of medications. A pharmacy manager can provide documentation that you have already advanced beyond this third stage.

The Pharmacy Technician's fourth stage will be the evolution of our position and responsibilities as health care professionals, continuing to earn respect and recognition from our clients and fellow staff members.

As official participants in the health of our communities, we will continue to provide the excellent, knowledgeable and professional care expected of pharmacy personnel.

Faye Elliott, CPhT, Pharmacy Office Manager
Guilford County

Major Goals Accomplished

First, everyone should be gratified to see what can be accomplished when all parties work together. The legislation accomplished four major goals in my opinion.

1. The entry avenues for clerks and cashiers to become pharmacy technicians were not closed.

2. A pathway was created for pharmacies operating under the proper criteria to increase the number of technicians that their pharmacists may supervise. This action provides pharmacists a way to respond to the increase in Rx volume and the pharmacist shortage.

3. The bar was raised for technician proficiency in our state. Now technicians are recognized as a legal entity under the law. By now being registered with the BOP their employment activities can be tracked.

4. Organized pharmacy in North Carolina has taken the first step in a paradigm shift that will result in the pharmacist being able to supervise the process of filling and dispensing a prescription, rather than performing the process.

Jimmy Jackson, Vice President of Pharmacy Relations
Eckerd Corporation

Tremendous Benefit For Patients

The new Pharmacy Technician Bill will create changes in the workplace for Techs and Pharmacists alike. Under the supervision of a pharmacist, technicians can perform technical functions to assist in preparing and dispensing prescription medication for the patients. This will be a tremendous benefit to the public in many ways.

The technicians will be under the rules and regulations of the North Carolina Board of Pharmacy, the same as pharmacists are now. This will be a benefit for the safety and welfare of the patients.

Jack G. Watts, President
North Carolina Board of Pharmacy

PTCB Exam: NC Techs Passing Rate Far Exceeds National Average

Congratulations to the many North Carolina Pharmacy Technicians who have passed the PTCB Exam and are now nationally certified. North Carolina had a passing rate of 93% for the July 14 exam, well above the national average of 81%. Since 1995, North Carolina's passing rate has averaged 90%. The national average passing rate is 80%.

Pharmacy Technician Certification Board Exam Results

Summary of Candidate Performance for North Carolina

Exam Date	# who sat	# who passed	% passed
1995-99 Exams	1,129	992	88%
March 25, 2000	70	62	89%
July 22, 2000	188	181	96%
Nov. 18, 2000	261	243	93%
March 10, 2001	131	117	89%
July 14, 2001	337	312	93%
TOTALS	**2,116**	**1,907**	**90%**

Summary of Candidate Performance National Statistics

Exam Date	# who sat	# who passed	% passed
1995-99 Exams	58,382	47,973	82%
March 25, 2000	8,101	6,206	77%
July 22, 2000	12,317	10,006	81%
Nov. 18, 2000	12,941	9,520	74%
March 10, 2001	8,442	6,116	72%
July 14, 2001	12,057	9,799	81%
TOTALS	**112,240**	**89,620**	**80%**

CONTINUING EDUCATION

In order to better serve our members NCAP will mail a special CE Supplement only to members who request it. CE is no longer published in the North Carolina Pharmacist, leaving more room for news of interest to all readers. As always, Continuing Education is available only to members. Members who would like to be added to the mailing list for CE should contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 27.

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PHARMACIA

Small Doses

The Drug Store of Lincolnton Earns Pharmacy of the Year Award

The Drug Store of Lincolnton, North Carolina, owned by NCAP member George Brookins, was named the McKesson Health Mart Pharmacy of the Year at the McKesson Trade Show held in Las Vegas, Nevada June 28 - July 1. More than 4,200 independent retail pharmacies are part of the McKesson Valu-Rite and Health Mart family of independent pharmacies. The Drug Store was selected for its commitment to its community as well as the innovative business procedures and systems it has implemented. Brookins was also acknowledge for his community involvement that includes serving as executive vice president for Hospice of Charlotte, and chairperson for the March of Dimes Walk-a-thon. He also organized an annual benefit golf tournament to benefit college scholarships in the community.

Senior PHARMAssist Receives Prestigious Leadership Grant

NCAP member Gina Upchurch, Executive Director of Senior PHARM*Assist* in Durham, has received a Robert Wood Johnson Foundation Community Health Leadership grant. The prize for this prestigious award is $100,000, most of which will be used to enhance Senior PHARM*Assist's* efforts and possibly expand services into other communities. The community-based, nonprofit Senior PHARM*Assist* program was founded by Gina in 1994 to help seniors with limited incomes obtain medication. The program also works to improve health literacy and links seniors to other community resources including meals and transportation. Over the last five years Senior PHARM*Assist* has earned three statewide awards and one national award for its comprehensive, innovative approach to healthcare for seniors.

New Medicap Pharmacy Opens

Friends, family members and city officials joined NCAP member Susan Harris on June 27 for a ribbon cutting ceremony to open her new Medicap Pharmacy in Fuquay-Varina. The 2000 square foot store features a drive-thru window, a prescription drop box, free delivery and a consulting room.

CPFI Elects New Officers

Officers were elected at the 14th Annual Meeting of the Christian Pharmacists Fellowship International held recently in Myrtle Beach, South Carolina. NCAP Executive Director Fred Eckel was elected to serve as Executive Director of CPFI. Elected Board Members included Pitt Phillips of Lincolnton, North Carolina. CPFI is a nondemoninational pharmacy organization which has approximately 1,400 members worldwide.

Pharmacists Mutual Companies Announce $1.6 Million Expansion

Pharmacists Mutual Companies, a provider of insurance and financial products and services to members of the pharmacy profession, recently announced plans for a $1.6 million expansion to their home office headquarters in Algona, Iowa. The expansion will add 7500 square feet of floor space and provide workspace for an additional 30-35 employees.

Pharmacists Mutual has been a part of the Algona community since it was founded in 1909. The company moved to its current location in 1971 and has gone through two expansions since that time. This third expansion is necessary to keep pace with the company's continuing growth and expansion into additional states. Pharmacists Mutual Companies consists of five companies, Pharmacists Mutual Insurance Company, Pharmacists Life Insurance Company, Pro Advantage Services, Inc., Pharmacists National Insurance Corporation, and PMC Quality Commitment, Inc. The company currently has approximately 180 employees, 144 work in the home office and three branch offices, as well as 36 field representatives. Completion for the expansion project is expected for July 2002.

VIAL LIFE

The Vial of Life program, sponsored by the NCAP Auxiliary, is designed to provide essential medical information to emergency medical personnel. The availability of up-to-date medical and prescription information during an emergency is essential for everyone, particularly for those who live alone or have special medical needs.

Pharmacists provide a 16 dram snap cap vial, two Vial of Life stickers, and a medical history form to an individual. That person is instructed to complete the medical history form and place it in the vial to which one Vial of Life sticker is attached. The second sticker is placed on the outside of the refrigerator and the vial is placed in the refrigerator on the top right hand shelf. It would be helpful if pharmacists would assist in completing the medical history form and provide a printout of their prescription record. Medical personnel are trained to check the refrigerator for a Vial of Life sticker and to look inside for the prescription vial containing the medical information.

The Auxiliary would encourage your continued participation in this project. Vial of Life stickers and medical history forms can be obtained from the NCAP Auxiliary at the Institute of Pharmacy, 109 Church St., Chapel Hill, NC 27516, ph: 919.967.2237. Stickers are $0.04 and medical history forms are $0.05.

Calendar

November 15-16: ***Osteoporosis Care Certificate Program*** Wake AHEC, Raleigh. NCAP is sponsoring this NIPCO-ACCREDITED program provided by the National Association of Community Pharmacists. Register online or direct e-mail inquiries to www.wakeahec.org

December 2-6: ***ASHP Midyear Clinical Meeting and Exhibits***, New Orleans, LA. For more information see "Meetings & Education" at www.ashp.org or call 301.657.4383.

Please visit the NCAP website at www.ncpharmacists.org for more information on upcoming meetings and events.

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Full Name:_____ Degree:_____ DOB_____

Title & Work Address: _____

_____ Work Phone:_____

Work Fax:_____ Work E-Mail: _____

Home Address: _____

_____ Home Phone:_____

Home Fax:_____ Home E-Mail: _____

I prefer to receive mail/e-mails/faxes at: ❒ Work Address ❒ Home Address

College:_____ Class Year: _____ NC Pharmacist License # _____

Political Representation: County:_____ US Representative:_____

State Representative:_____ State Senator: _____

*MEMBERSHIP CATEGORIES & DUES: PLEASE CIRCLE ONE

NEW MEMBERS can JOIN NOW and receive membership through Dec. 31, 2002!

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Pharmacist Spouse	$ 95	(please attach additional application for spouse)
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Technician	$ 35	
Student	$ 10	

All membership dues include membership in a primary Practice Forum. Please select your practice forum(s):

❒ Acute Care (hospital) ❒ Ambulatory Care (community) ❒ Chronic Care (long-term) ❒ Technician

Members can join secondary forums for $25 each. Secondary Practice Forum(s): _____

PLEASE NOTE: Beginning in 2002 your local membership dues will not be collected by NCAP. If you wish to join a local association visit www.ncpharmacists.org for a list of contacts or call NCAP at 800-852-7343.

Name of local association: _____ Are you a member of your local assoc.? ❒ Yes ❒ No

New in 2002: For an additional $95 (minimum) you can become a member of the NCAP President's Club. Benefits include special recognition at NCAP meetings and in our journal, North Carolina Pharmacist.

Membership Dues:	$ _____
Contribution to President's Club ($95 minimum)	$ _____
TOTAL ENCLOSED:	$ _____

❒ Check Enclosed ❒ Visa ❒ Mastercard Credit Card #:_____ Exp. date:_____

Signature: _____ Date:_____

If you're using a credit card you may fax this form to (919) 968-9430 Otherwise, please mail the form and your check to:

NCAP, 109 Church Street, Chapel Hill, NC 27516

1-800-852-7343

* 50% of your membership dues are non-deductible for Federal income tax purposes due to lobbying activities conducted by the association of behalf of its members.

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